An analysis of how EU law can contribute to controlling the addictiogenic environment

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The objective of this thesis is to provide an analysis of the contribution that the European Union (EU) could make to the prevention of addiction. The EU is empowered to support its Member States in the public health field through the adoption of legal acts, and has the power to regulate the internal market with public health goals in mind. Recent Treaty revisions has also recognised the EU's role in the prevention of harm arising from tobacco and excess alcohol consumption.

Yet, the EU has no addiction prevention strategy of its own, and the public health and social problems caused by addiction are barely mentioned in public health policy discourse at EU level. This thesis will argue that a renewed and more intense strategic approach to addiction prevention is needed across Europe, and especially at EU level, if the currently high prevalence of addiction is to be reduced. Addiction, it will be argued, is a complex problem, but one which is ultimately caused by the influence of the social environment. The right legal intervention can reshape this environment to weaken its influence upon individuals who are vulnerable to developing addictions. The thesis will argue that the EU has both the mandate and the legal capacity to contribute to such intervention, and will offer suggestions as to how such a contribution might be designed and defended.

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List of Abbreviations

CJEU – Court of Justice of the European Union

ECHR – European Convention on Human Rights

ECtHR – European Court of Human Rights

EU - European Union

CFREU – Charter of Fundamental Rights of the European Union

FCTC – Framework Convention on Tobacco Control

ICESCR – International Covenant on Economic, Social and Cultural Rights

NCD - non communicable diseases

OMC – Open Method of Coordination

TFEU – Treaty on the Functioning of the European Union

TEU – Treaty on European Union

UDHR – Universal Declaration of Human Rights

Statement of Copyright

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CHAPTER ONE – INTRODUCTION

The objective of this thesis is to provide an analysis of the contribution that the European Union (EU) could make to the prevention of addiction. For over twenty years the EU has been empowered to support its Member States in the public health field through the adoption of legal acts. Since the turn of the millennium, the Court of Justice of the European Union (CJEU) has recognized that the EU legislature has the power to regulate the internal market with public health goals in mind. Moreover, for nearly a decade the EU has specifically had the power to adopt incentive measures that will prompt control of the markets for alcohol and tobacco, two common objects of addiction. These powers could be used to complement the work of the many EU Member States that have created dedicated addiction prevention strategies to try to halt the rising numbers of individuals who have developed an addiction.

Yet, the EU has no addiction prevention strategy of its own, and the public health and social problems caused by addiction are barely mentioned in public health policy discourse at EU level. This thesis will argue that a renewed and more intense strategic approach to addiction prevention is needed across Europe, and especially at EU level, if the currently high prevalence of addiction is to be reduced. Addiction, it will be argued, is a complex problem, but one which is ultimately caused by the influence of the social environment. The right legal intervention can reshape this environment, in order to weaken its influence upon vulnerable individuals and communities. The thesis will argue that the EU has both the mandate and the legal capacity to contribute to such intervention, and will offer suggestions as to how such a contribution might be designed and defended.

This introductory chapter will set the scene by laying out the public health context in which renewed EU action on addiction should be attempted, explaining the methodology that will be employed to conduct this analysis, and providing an overview of the chapters that this analysis will be divided into.

I. Global public health context of the analysis

In 2011, the global community committed, through the adoption of the United Nations Political Declaration on the Prevention and Control of Non-Communicable Diseases,[1] to substantially increase the actions they were currently taking to reduce the world's growing burden of non-communicable

[1] Resolution A/66/L.1 of the United Nations General Assembly.

disease.[2] Non-communicable disease, or NCDs, is the general term given to chronic diseases that are not transmittable from one individual to another.[3] Their causes are usually (not always, but usually) related to an individual's lifestyle, and the four primary risk factors for the majority of NCDs are tobacco consumption, excessive alcohol consumption, excessive consumption of unhealthy foods and beverages, and lack of physical exercise.[4] These factors are modifiable, which makes it possible to prevent the development of NCDs.[5] However, far from being prevented, the prevalence of NCDs is still high – WHO figures suggest that in 2012, 38 million deaths, 63 per cent of all global deaths, were caused by NCDs, of which 40 per cent were premature deaths under the age of 70.[6] In Europe, the burden of NCDs is particularly acute – 87 per cent of deaths and 77 per cent of the disease burden in Europe are attributable to NCDs.[7]

The Political Declaration acknowledged that these statistics are unacceptable. Through it, heads of state and government recognised that 'the global burden and threat of non-communicable diseases constitutes one of the major challenges for development in the twenty-first century',[8] that rising levels of non-communicable disease 'can be largely prevented and controlled through collective and multisectoral actions by all Member States and other relevant stakeholders at the local, national, regional and global levels',[9] and that 'urgent need for greater measures at the global, regional and national levels'[10] is required.

The political commitment of the Declaration was followed up by the adoption, under the auspices of the WHO, of a Global action plan for the prevention of NCDs,[11] the purpose of which is to provide public policymakers with 'a road map and menu of policy options'. It sets out 9 global NCD targets including a reduction of premature mortality from NCDs by 2025.[12] This global call to action was followed by the adoption of regional action plans, including the Action Plan for implementation of

[2] On the rising global burden of non-communicable disease, see the *Global action plan for the prevention and control of NCDs 2013-2020* (World Health Organization 2013). See also: A Daar et al, 'Grand challenges in chronic non-communicable diseases' (2007) 450 Nature 494.
[3] See the WHO Factsheet on Noncommunciable diseases, available at http://www.who.int/mediacentre/factsheets/fs355/en/ (last accessed 25 July 2016).
[4] *Global action plan for the prevention and control of NCDs 2013-2020* (World Health Organization 2013), 1.
[5] R Beaglehole et al, 'Priority actions for the non-communicable disease crisis' (2011) 377 Lancet 1438, 1438.
[6] See the *Global status report on noncommunicable diseases 2014* (World Health Organization 2014), xi.
[7] *Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012-2016* (World Health Organisation Regional Office for Europe 2012), document EUR/RC61/12, 1.
[8] Resolution A/66/L.1 of the United Nations General Assembly, para 1.
[9] ibid, para 33.
[10] ibid, para 6.
[11] Resolution 66.10 of the World Health Assembly, available online at www.int/nmh/events/ncd_action_plan_/en/. (last accessed 25 July 2016).
[12] *Global action plan*, n 4 above, 1.

the European Strategy for the Prevention and Control of Noncommunicable Diseases,[13] a strategy that had already existed[14] before the surge in political recognition that current levels of action were insufficient.

Although it is well recognised that NCDs have four main risk factors, it is less often acknowledged that three of the products implicated in these four risk factors, namely tobacco, alcohol and unhealthy foods and beverages, are also capable of becoming objects of addiction.

The fact that many NCD risk factors can also be objects of addiction raises four further problems for NCD prevention. First, when products such as alcohol, tobacco and unhealthy foods are consumed as part of an addiction, the levels of consumption will be much higher even than consumption levels that are already classed as heavy and hazardous. Therefore, the health risks posed by products such as alcohol, tobacco and unhealthy foods are exponentially higher when they are consumed addictively, especially when the individual's addiction causes them to ignore those health risks.[15]

Second, addictions are often comorbid – meaning that once an individual has developed one addiction, the chanced of them developing further addictions at the same time is increased. An individual addicted to a product that is an NCD risk factor might also have a comorbid addiction to a product or service that is not an NCD risk factor. For example, there is significant comorbidity between gambling addictions and alcohol addictions.[16]

Third, while heavy or hazardous consumption of objects such as alcohol, tobacco or unhealthy foods might be reduced in a relatively predictable way through intervention on the factors proximate to the consumption of those products, addictive consumption has a far wider causal nexus, some factors of which actively resist control by policymakers.[17] Therefore the interventions required in order to prevent addictive consumption, as opposed to heavy and hazardous consumption, need to reach further and deeper than policymakers sometimes realise.

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[13] European Action Plan, n 7 above.

[14] *Gaining health: The European Strategy for the Prevention and Control of Noncommunicable Diseases* (World Health Regional Office for Europe 2006).

[15] H Clarke, 'Addictive consumption under conditions of risk' (2000) 76(234) The Economic Record 263.

[16] See for example: A Lawrence et al, 'Problem gamblers share deficits in impulsive decision-making with alcohol-dependent individuals' (2009) 104 Addiction 1006;
H Shaffer and D Korn, 'Gambling and Related Mental Disorders: A Public Health Analysis' (2002) 23 Annual Review of Public Health 171.

[17] See for example: M Clarke and J Stewart, 'Handling the wicked issues' in J Reynolds et al (eds), *The Managing Care Reader* (London: Routledge 2003), 273.

The fact that the majority of NCD risk factors are potential objects of addiction therefore makes the task of reducing the health burden of NCDs extremely complex. It is against this background of complexity that Member States, supported by the EU, must engage with the prevention of NCDs, and the phenomenon of addiction. This thesis will offer an analysis of the legal aspects of this process, and how legal intervention can be designed in accordance with available scientific in order to maximise its potential effectiveness as a tool of addiction prevention. The next section describes the methodology used to carry out this analysis.

II. Methodology

This thesis will attempt to illustrate how law is relevant to addressing complex public health and social problems, and how law could be reformed in order to better address that problem. It will therefore be necessary to draw upon a combination of epidemiological analysis, legal analysis and policymaking analysis.

Epidemiological analysis will be relied upon to explain the nature of the addiction problem. If law is to be used in order to shape the environment in such a way as to improve the health of populations, the characteristics of that environment must be established. Public health epidemiology is 'the study of the distribution and determinants of health-related state or events in specified populations'.[18] As such, it provides the 'ammunition for public health practitioners'[19] to be able to address particular public health problems. An epidemiological approach will be used to identify the nature of the addiction phenomenon, and to identify the bodies of evidence that should inform the application of law to these problems. It will consequently be necessary to draw on a wide body of scientific literature that is relevant to the phenomenon of addiction, including literature from the psychological sciences, behavioral sciences, medical sciences and social sciences.

Legal analysis will facilitate an explanation of why law is a legitimate tool through which policy makers should control environments that are likely to encourage the development of addictions. Since this thesis focusses on the contribution that the EU could make to addiction policy, legal analysis will focus upon the principles of EU constitutional and internal market law, drawing upon related literature for support, in order to identify the sources of EU legal power relevant to addiction

[18] J Last, 'Epidemiology and ethics' (1991) 19(3-4) Law, Medicine and Health Care 166, 166.
[19] J Lomas, 'Social capital and health: implications for public health and epidemiology' (1998) 47(9) Social Science and Medicine 1181, 1181.

prevention, and how these powers might be exercised. The legal analysis will also have to explain why particular laws should be made in order to achieve particular goals. This involves drawing upon a research tradition that has been identified as public health law research. Public health law research can be defined as 'the scientific study of the relation of law and legal practices to population health'.[20] Unlike the doctrinal legal analysis above, public health law research is 'concerned not with what is right, proper, or legitimate to include within the jurisdiction of public health law but with whether law can be empirically shown to have an impact on the health of the population'.[21] Drawing on public health law research literature will therefore add a socio-legal perspective to the analysis, facilitating and explanation of why certain legal interventions are appropriate to solve certain public health and social problems.

Finally, policy analysis will be used as a tool to explain how legal interventions designed to prevent addiction are to be adopted. Policy analysis can be understood as 'a process of multidisciplinary inquiry aiming at the creation, critical assessment, and communication of policy-relevant information'.[22] It is a 'problem solving discipline' which 'draws on social science methods, theories and substantive findings to solve practical problems'.[23] As such, a policy analysis approach will be an effective lens through which the practical policymaking aspects of addiction prevention can be examined. The policy analysis of this thesis will draw upon policy design literature, problem definition literature, literature on the politics of public health, and governance literature.

Just as addiction is a complex problem, the analytical approach used to dissect it is necessarily a complex one. The above three methodological approaches will be therefore used in a complimentary way throughout the thesis, which will attempt to weave together different perspectives on addiction scholarship to produce a coherent explanation of why law should be relevant to addressing the addiction phenomenon.

III. Chapter Overview

This thesis is divided into nine chapters – the current introductory chapter, seven substantive chapters, and a concluding chapter. Chapters two, three and four will provide the theoretical foundations for the analysis of how legal intervention can most effectively contribute to addiction

[20] S Burris et al, 'Making the case for laws that improve health: a framework for public health law research' (2010) 88(2) Milbank Quarterly 169, 171.
[21] ibid, 172.
[22] W Dunn, *Public Policy Analysis*, 5th Ed (Oxon: Routledge 2015), 2.
[23] ibid.

prevention. Chapters five and six will analyse the current state of addiction prevention at the Member State and EU levels. Chapter seven and eight will then examine how a more intense legal approach to addition prevention might be designed and implemented, with a particular focus on the EU level.

Chapter Two starts by surveying the literature on the three main theories of addiction – the disease model, the free will model and the environmental determinants model. It will conclude that an environmental understanding of addiction provides the best explanation of what the phenomenon is, but that something further is needed to explain *how* addictions are developed. Thus, an addictiogenic environment model of addiction development is set out, arguing that the development of any addiction consists of three elements – the experience of social dislocation, the capacity to form a pseudo-relationship, and the potential for vocational consumption. The analysis throughout the rest of the thesis will be conducted upon the understanding that the environmental factors that promote social dislocation, encourage pseudo relationships and facilitate vocational consumption are the root of the addiction problem.

Chapter Three will set out the normative justifications for the use of law in controlling the factors of the addictiogenic environment. Two normative cases for action will be put forward – the existence of the right to health in international law, and the ethical obligations that are placed on public authorities by the stewardship and social justice principles.

Chapter Four will complete the theoretical foundations of the thesis by setting out why the EU should and could contribute to controlling the factors of the addictiogenic environment through legal intervention. After first explaining why EU policymakers should take responsibility for addressing transnational factors of the addictiogenic environment, the chapter will analyse three legal bases for EU action, Article 168 TFEU (the public health competence), Article 153 TFEU (the social policy competence) and Article 114 TFEU (the internal market competence). This analysis will reveal the extent to which the Treaties empower the EU to contribute towards the control of the addictiogenic environment for the purposes of preventing the development of addictions.

Chapter Five will utilise the theoretical foundations provided in the previous chapters to assess the degree to which current Member State approaches to addiction prevention are likely to result in effective legal intervention. The addiction strategies of three Member States – Germany, France and Spain – will be examined, in order to determine whether their supposedly comprehensive addiction

policies are likely to produce a sufficiently comprehensive response to the addictiogenic environment. It will be shown that none of these Member State have been able to capture the full complexity of the addictiogenic environment, despite it being possible to identify best practice for achieving this across the three Member States' approaches.

Chapter Six will then examine the extent to which the EU has supported its Member States in tackling the factors of the addictiogenic environment. Since the EU has adopted a sectoral approach to addiction policy, three fields of policy will be analysed – tobacco, alcohol and gambling – and an assessment made of the strength of the EU's contribution towards effective legal control of the addictiogenic environment. It will be shown that the EU has failed to discharge its responsibilities for tackling transnational factors of the addictiogenic environment.

Chapter Seven will build upon the findings of the preceding two chapters, and will put forward suggestions for how a more intense strategic approach to addiction might be designed. It will argue that renewed strategic intervention on addiction must be guided by clear goals and appropriate policy paradigms, and will discuss specific examples of legal intervention that could be considered by EU policymakers as part of a more intense approach to addiction prevention.

Chapter Eight will identify the challenges that will be faced in attempting to implement legal intervention that is more intense than what has previously been attempted. The chapter will argue that addiction industries will oppose strong addiction interventions in two important ways – first through the agenda-setting power they have accumulated in the policymaking process, and second through the fundamental rights challenges they might make to addiction interventions. It will be argued that policymakers can find ways to overcome both of these hurdles.

Chapter Nine, the concluding chapter, will summarise the lessons that can be drawn from the analysis conducted in the main body of the thesis. It will highlight the salient points that national, and in particular EU level, policy makers should direct attention to when engaging with the problem of the addictiogenic environment, and will suggest next steps for moving the current situation forward.

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CHAPTER TWO – THE ADDICTION PROBLEM

I. Introduction

In order to correctly frame the analysis of how addiction is being addressed now, and how it might be addressing in the future, the nature of the addiction problem must be identified. The development of addictions constitutes a serious public health and social problem in Europe. Statistics from the European Health Interview Survey show that an average of 24 per cent of EU citizens are daily cigarette smokers.[24] According to the report Alcohol in Europe conducted for the European Commission, an estimated 23 million Europeans are addicted to alcohol in any one year.[25] Furthermore, the Commission's Communication on Online Gambling notes that between 0.5 and 3 per cent of the European population has a gambling addiction,[26] which in absolute terms equates to between 2.54 and 15.24 million people. As Chapter One highlighted, if one develops an addiction to a product that is an NCD risk factor, the health consequences can be extremely severe. However, development of NCDs is not the only harm that may result from an addiction, and substances such as alcohol, tobacco and unhealthy foods, are not the only harmful addictive objects. Gambling addictions can lead to a variety of serious mental conditions including major depression and bipolar disorder, and are also linked to suicide attempts, family dysfunction and domestic violence.[27] Addictions to Internet based social networking sites can lead to serious social harms, such as the undermining of self-esteem and negative consequences in romantic relationships.[28] Moreover, research suggests that simply leading an addicted lifestyle is harmful to individuals – for example, the stigmatisiation attached to addiction prevents many addicted individuals from seeking assistance.[29]

[24] See 'Tobacco Consumption Statistics' at http://ec.europa.eu/eurostat/statistics-explained/index.php/Tobacco_consumption_statistics (last accessed 19 September 2016).
[25] P Anderson and B Baumberg, *Alcohol in Europe* (London: Institute of Alcohol Studies 2006), 3.
[26] Commission Communication, Towards a comprehensive European framework for online gambling, COM(2012) 596 final, 11.
[27] For a summary of the evidence, see: Shaffer and Korn, n 17 above, 177
[28] D Kuss and M Griffiths, 'Online social networking and addiction – a review of the psychological literature' (2011) 8 International Journal of Environmental Research and Public Health 3528, 3537.
[29] A Lavack, 'Using social marketing to de-stigmatize addictions: a review' (2007) 15(5) Addiction Research and Theory 479, 480.

Addiction cannot therefore be ignored – there is a link between the development of addictions and the development of NCDs, and a link between addiction development and a wide range of other health and social harms. In order to prevent the harms that can result from the development of any addiction, the phenomenon of addiction itself must be examined, to uncover what 'addiction' is, and how it is developed.

The first section of this chapter will explore how addiction has been theorised, and will argue that environmental theories, specifically the social dislocation theory, best explain what addiction is. The second section will build on the social dislocation theory, proposing that an expanded social dislocation theory – the *addictiogenic environment model* – could be used to explain how addictions develop.

II. Explaining what addiction is and how it is caused

The scientific, sociological, political, legal and economic literatures have been grappling with the nature of addiction for some time.[30] The fact that it is common for individual to be addicted to two or more completely different objects at the same time[31] has prompted scholars to recognise an underlying addiction *phenomenon*, a 'shared etiology'[32] that explains the fact that 'many commonalities occur across different expressions of addiction'.[33] If one accepts the proposition that the causes of any particular addiction – whether it is to alcohol, tobacco, the Internet, or anything else – are essentially the same mechanism, then one must explain what this mechanism is. Theories on the mechanism underlying the development of addictions generally fall into one of three camps: theories that addiction is a disease; theories that addiction is a consequence of personal characteristics; and theories that addiction is a response to environmental conditions. These groups of theories will be explored in the sections below.

[30] See the taxonomy by Robert West of various theories of addiction that have accumulated over time: R West, *Models of addiction* (European Monitoring Centre for Drugs and Drug Addiction 2013), 32.
[31] For illustrations, see: J Dani and R Harris, 'Nicotine addiction and comorbidity with alcohol abuse and mental illness' (2005) 8(11) Nature Neuroscience 1465, 1468; SH Rhee et al, 'Comorbidity between alcohol dependence and illicit drug dependence in adolescents with antisocial behavior and matched controls' (2006) 84 Drug and Alcohol Dependence 85.
[32] H Shaffer et al, 'Towards a syndrome model of addiction: multiple expressions, common etiology' (2004) 12 Harvard Review of Psychiatry 367, 368
[33] ibid.

A. Disease theories

The theory that addiction is a disease is perhaps the oldest. The central argument of all disease theories is that individuals are not responsible for the behaviour that they exhibit, either because they are biologically predisposed to addiction, or because ingestion of a substance has co-opted their biological functioning.[34] Several variants have emerged over the years, from claims that addiction is a disease of morals, to claims that addiction is a physiological disease characterised by cycles of tolerance and withdrawal, to claims that addiction is a neurological condition.[35]

Since the 1990s, when advances in neuroimaging permitted scientists to study the human brain far more accurately, theories of addiction as a disease have focussed on the co-option of brain function by various substances.[36] One of the foremost proponents of this theory of addiction, Alan Leshner, wrote that 'virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain'[37] – the brain's reward system – and 'activation of this system appears to be a common element in what keeps drug users taking drugs'.[38] He argued that 'the addicted brain is distinctly different from the nonaddicted brain' and that the fact 'that addiction is tied to changes in brain structure and function is what makes it, fundamentally, a brain disease'.[39] A multitude of different studies have subsequently produced evidence that apparently supports the view that co-option of brain circuitry by a substance is responsible for causing addictive behaviour.[40]

However, despite advances in neuroscience, and the mountain of scientific studies produced to support the disease model of addiction, an explanation of addiction as a biological disease is unsatisfactory. As Reinarman points out, 'despite deceases of research, the biological basis for addiction-as-disease remains elusive'.[41] Quite simply, although there seems to be a mountain of scientific evidence that is raised in support of the disease model, this evidence does not conclusively show that sustained ingestion of substances, irrespective of what they are, will consistently alter human biology in a way that produces addictive behaviour.[42] Hall and colleagues argue that the

[34] W White, 'Addiction disease concept: Advocates and critics (2001) 2(1) The Counselor 42.
[35] See C Reinarman, 'Addiction as accomplishment: the discursive construction of disease' (2005) 13(4) Addiction Research and Theory 307.
[36] B Foddy, 'Addiction and its sciences – philosophy' (2010) 106 Addiction 25, 26.
[37] A Leshner, 'Addiction is a brain disease, and it matters' (1997) 278 Science 45, 46.
[38] ibid.
[39] ibid.
[40] See for example: S Hyman, 'Addiction: A disease of learning and memory' (2005) 162, American Journal of Psychiatry 1414; N Volkow and J Fowler, 'Addiction, a disease of compulsion and drive: involvement of the orbitofrontal cortex' (2000) 10 Cerebral Cortex 18.
[41] Reinarman, n 35 above, 308.
[42] E Becoña, 'Addiction is *not* a brain disease' (2016) 37(2) Psychologist Papers 118, 120.

evidence adduced to support addiction as a disease is problematic for five reasons – the chronic nature of the disease is unsupported, the fact that animal studies are a poor reflection of human behaviour, the fact that genetic studies are not informative, the fact that bias exists in neuroimaging sample sizes, and the sheer complexity of the neurobiology of addiction.[43]

If evidence raised to support the disease theory of addiction does not particularly bear out the theory, taking a step back from biological functioning shows that biology is only one facet of the addiction phenomenon. As Satel and Lilienfeld argue, biological brain function is not the only factor implicated in the development of addictions,[44] and as Dingel et al argue, reducing the addiction phenomenon to a matter of neuroscience overlooks the 'complex biopsychosocial context'[45] in which addiction arises. Furthermore, as Reinarman points out, the more times the disease model of addiction is re-approached, redefined and reapplied, including being applied to objects of addiction that are not substances at all, the more the notion of an addiction 'disease' is shown to lack any theoretical credibility.[46] In summary, the disease model of addiction is an overly one-dimensional way of approaching the complex phenomenon of addiction, and cannot sufficiently explain how or why individuals might develop addictions.

B. Free will theories

A second group of theories claim that addiction is not a disease, but a failure of free will, a consequence of certain personal characteristics overcoming others in the determination of behaviour. One of the leading proponents of the free will theory of addiction has been Jeffrey Schaler, who has argued that 'humans are capable of deliberate action in pursuit of chosen goals'.[47] His view is that since 'all such voluntary human action is ultimately under conscious control',[48] the adoption and cessation of addictions are voluntary, conscious choices. Others have taken the free will theory even further, to argue that the term 'addiction' does not merely describe a life choice, but is a social construct[49] created by dominant social groups, who see fit to categorise a set of choices that do not conform to the group's expectations of restraint and social compliance as a

[43] W Hall et al, 'The brain disease model of addictions: is it supported by the evidence and has it delivered on its promises?' (2015) 2 Lancet Psychiatry 105.
[44] S Satel and S Lilienfeld, 'Addiction and the brain-disease fallacy (2014) 4 Frontiers in Psychiatry 141.
[45] M Dingel et al, 'Framing Nicotine Addiction as a "Disease of the Brain": Social and Ethical Consequences' (2011) 92(5) Social Science Quarterly 1363, 1364.
[46] Reinarman, n 35 above, 308-309.
[47] J Schaler, *Addiction is a Choice* (Peru, IL: Open Court Publishing 2000), 8.
[48] ibid.
[49] On the idea of addiction as a social construction, see: H Shaffer, 'Toward an Epistemology of "Addictive Disease"' (1991) 9 Behavioral Sciences and the Law 269, 273.

harmful decision to forego self-control.[50] Thus, the argument made by proponents of the free will model is that addiction is the consequence of a socially undesirably choice to relinquish control over behaviour.

As with the disease model, scientific evidence is available to support the theory that 'thoughts, desires, values and other mental phenomena can dominate bodily functions'[51] and lead to a loss of control. For example, proneness to 'deviant' patterns of behaviour predicts addictive behaviour,[52] as does impulsivity as a personality trait,[53] as does shyness and internality (the degree to which individuals believe they have control over their lives) as a psychological belief.[54]

Furthermore, a free will theory of addiction explains several aspects of the addiction phenomenon that cannot be explained by the disease model. First, it explains why most objects of addiction tend to be pleasurable, even if their consumption is not normally or not always harmful to health. Pleasurable or visceral products and services[55] are often objects of hedonistic consumption, a type of consumption that is associated with 'the search for instant gratification'.[56] Such a consumption ideology has often been viewed with distaste or disapproval by dominant social groups throughout history,[57] and thus objects that lend themselves to hedonistic consumption have often been branded as 'addictive', and those who are perceived to consume them in excess are branded as 'addicts'. Good examples of objects of pleasure and hedonism that are not inherently harmful yet are often branded as 'addictive' are sexual activity[58] or online shopping.[59]

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[50] G Reith, 'Consumption and its discontents: addiction, identity and the problems of freedom' (2004) 55(2) The British Journal of Sociology 283, 284.
[51] Schaler, 'Addiction Is a Choice' (*The Psychiatric Times*, October 1 2002) available online at http://www.psychiatrictimes.com/addiction/addiction-choice/page/0/1 (last accessed 26 July 2016).
[52] K Sher et al, 'The development of alcohol use disorders' (2005) 1 Annual Review of Clinical Psychology 493, 499.
[53] S Fischer and G Smith, 'Binge eating, problem drinking, and pathological gambling: Linking behaviour to shared traits and social learning' (2008) 44 Personality and Individual Differences 789, 790.
[54] K Chak, 'Shyness and locus of control as predictors of Internet addiction and internet use' (2004) 7(5) CyberPsychology and Behaviour 559, 567.
[55] J Leitzel, *Regulating Vice* (Cambridge University Press 2008), 51.
[56] J O'Shaughnessy and N O'Shaughnessy, 'Marketing, the consumer society and hedonism' (2002) 36(5) European Journal of Marketing 524, 525.
[57] K Klaue, 'Drugs, addiction, deviance and disease as social constructs' (1999) 51(1 and 2) United Nations Office on Drugs and Crime: Bulletin On Narcotics, available online at http://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1999-01-01_1_page005.html (last accessed 19 September 2016).
[58] J Irvine, 'Reinventing Perversion: Sex Addiction and Cultural Anxieties' (1995) 5(3) Journal of the History of Sexuality 429.
[59] S Rose and A Dhandayudham, 'Towards an understanding of Internet-based problem shopping behaviour: The concept of online shopping addiction and its proposed predictors' (2014) 3(2) Journal of Behavioral Addictions 83.

Consequently, the free will theory suggests that novel products or services, the use of which disrupts societally accepted norms of control and restraint, are likely to be pejoratively branded as "addictive", in an attempt to re-impose an element of societal control that is perceived to have been lost, even if those products are in most cases completely benign.[60]

The theory that addiction development is linked to free will is also better at explaining why addicted individuals often moderate their behaviour without any form of medical intervention or other form of external physical assistance.[61] Furthermore, it provides a more believable explanation for why addictions tend to be comorbid, why addictions to substances are often comorbid with behavioural addictions as noted above, and why addictions are also often comorbid with mental health conditions.[62]

We could draw some interesting lessons about addiction from the free will theory, particularly in relation to how the concept has been employed by some as a tool of social control. However, it too is flawed as a method of explaining what addiction is and how it is generated. Beyond the lose assertion that some objects are pleasurable and therefore invite a loss of control, the free will model does not provide any solid explanation as to exactly how and why an absence of will power, or the possession of certain personal characteristics, will lead to addictive behaviour. Impulsivity, deviance and shyness may indeed be correlated with addiction, however this does not prove that impulsive, deviant or shy people will become addicts. A person that is impulsive for example, will not be more likely to develop an addiction simply because they are impulsive. Rather, there must be hidden third variables present in the studies conducted on behavioural traits and addiction. For example, impulsivity may exacerbate an individual's reaction to a third variable, making it more likely that impulsive individuals exposed to this variable will develop addictions, yet the study itself will not necessarily reveal what this variable is. The free will model is thus useful for understanding the sociological framing of addiction, but cannot truly explain the mechanism behind the phenomenon. A good illustration of this is that the free will theory of addiction has no response when applied to

[60] An excellent recent example is the release of the augmented reality game Pokémon GO – the operation of the game has led to several instances of unregulated, sometimes unruly or antisocial, gatherings of people, and has consequently already attracted the label of an "addictive" game from conservative sections of society: 'Pokémon Go: What parents should know about the addictive mobile game their children are playing' (*Mirror Online,* 14 July 2016) available online at http://www.mirror.co.uk/tech/pokmon-go-what-parents-should-8403226 (last accessed 26 July 2016).

[61] Schaler, n 47 above, 8.

[62] E Jane-Llopis and I Matytsina, 'Mental health and alcohol, drugs and tobacco: a review of the comorbidity between mental disorders and the use of alcohol, tobacco and illicit drugs' (2006) 25 Drug and Alcohol Review 515, 521.

the great number of individuals who are intent upon, even desperate, to end their addictions, but cannot.[63]

In any event, the free will theory cannot hope to provide a satisfactory explanation for the addiction phenomenon because, like the disease theory, it takes too narrow a perspective on a complex phenomenon that 'may be construed in terms of biological, social or psychological processes, or some combination of these'.[64] Attempting to explain a complex social phenomenon using a theory derived from the fact that 'people think of themselves or others … to be morally responsible for something',[65] when 'people differ in their reasoning and intuitions around attributing causality to psychological and neurological mental states'[66] will only ever produce 'vigorous debates concerning the moral status of both addiction and the addicted person'.[67] Vigorous debates on moral status are not sufficient evidence on which to found legal intervention. Free will theories are therefore not helpful in explaining the aetiology of addiction, but rather only add to the 'conceptual confusion created by [hundreds of] years of moral discourse around addicted persons'.[68]

C. Environmental theories

Since the phenomenon of addiction cannot be adequately explained by the disease theory of addiction or the free will theory of addiction, some scholars have developed a third set of theories – environmental theories of addiction. These theories argue that it is in fact an individual's environment that stimulates the development of addictions. Several interesting variants have been put forward. Shaffer and colleagues contend that addiction is a 'syndrome', a cluster of symptoms and signs related to an abnormal underlying condition',[69] that can result from a combination of 'individual vulnerability levels, object exposure, and object interaction'.[70] They contend that 'throughout the course of development, people encounter and accumulate specific combinations of neurobiological and psychosocial elements that can influence their behaviour'.[71] Essentially, Shaffer and colleagues argue that addiction is a product of the totality of an individual's specific life-course experiences, and not simply a product of altered brain chemistry or lack of willpower. This would

[63] J Eiser et al, 'Trying to stop smoking: effects of perceived addiction, attributions for failure, and expectancy of success' (1985) 8(4) Journal of Behavioral Medicine 321.
[64] R West, 'Theories of addiction' (2001) 96 Addiction 3, 3.
[65] D Buchman et al, 'The paradox of addiction neuroscience' (2011) 4 Neuroethics 65, 73.
[66] ibid.
[67] ibid.
[68] ibid, 67.
[69] Shaffer et al, n 32 above, 367.
[70] Shaffer et al, n 32 above, 368.
[71] Shaffer et al, n 32 above, 368.

tend to explain why one group of people who consume addictive objects will become addicted and another group who consume them at similar levels will not. It would also explain why addictions are often comorbid, why some addictions are easily overcome while others are not, and the diversity of objects that individuals can become addicted to.

Gifford and Humphreys conceptualise addiction in a similar way. They argue that addiction is 'the action of multi-dimensional individuals behaving in a particular fashion in certain contexts'.[72] According to their theory, an individual's 'social context serves as both a risk factor and protective factor for substance use, playing and important role in addiction's initiation, escalation, maintenance and relapse; and conversely in its prevention, treatment and long-term resolution'.[73] Social contexts that can play a role in the development of addictions include 'the family, provider-patient relationships, treatment environment, peer groups and friendship networks, work settings, self-help organisations, neighbourhoods and cultural groups'.[74] Thus, the addiction phenomenon can be explained according to Gifford and Humphreys by looking to the quality and interaction of an individual's social relationships.

The advantage of environmental theories of addiction is that they approach the phenomenon in more holistic manner. They argue that addiction should be understood as a deeply complex response to life conditions, rather than a simple biological reaction, or a simple absence of willpower. Of all the environmental theories that have been put forward, the most detailed is Bruce Alexander's dislocation theory of addiction,[75] which will be considered below.

In essence, Alexander's theory is that the natural consequence of the globalisation of free market ideals is widespread social dislocation, and that addiction is an adaptation to cope with the experience of social dislocation. Alexander begins from the proposition that humans 'are not psychologically self-sufficient' and 'in every culture devote themselves to establishing and maintaining a place in their society'.[76] In return, society 'gives as much latitude as [it] can to individuals' unique preferences and needs for autonomy, but always within limits that allow each

[72] E Gifford and K Humphreys, 'The psychological science of addiction' 102 Addiction 352, 353.
[73] ibid.
[74] ibid.
[75] Alexander's theory is set out in: B Alexander, *The Globalisation of Addiction: A Study in Poverty of the Spirit* (Oxford University Press 2008).
[76] ibid, 58. See, from the psychological literature, on the importance of interpersonal relationships for human beings: R Baumeister and M Leary, 'The need to belong: Desire for interpersonal attachments as a fundamental human motivation' (1995) 117(3) Psychological Bulletin 497; E Dreikurs Ferguson, 'Adler's motivational theory: An historical perspective on belonging and the fundamental human striving' (1989) 45(3) Individual Psychology 354.

subgroup to carry out its essential economic and social functions'.[77] Alexander identifies this 'complex, ever-changing state of interdependence' in evolved human society as 'psychosocial integration', defined as 'a profound interdependence between individual and society that normally grows and develops through each person's lifespan'.[78] He argues that while there are many ways to build psychosocial integration, there are just as many ways to destroy it. Alexander identifies an 'enduring lack of psychosocial integration' caused by psychological and social separation from one's society' as 'social dislocation'.[79]

Alexander's theory then argues that 'globalisation of free-market society has produced an unprecedented, worldwide collapse of psychosocial integration'.[80] Over thousands of years, human civilisation has evolved a balance between social cooperation and individual expression.[81] Free markets ideals however encourage 'intense, unrelenting individual competition' between 'individual economic actor[s], pursuing his or her individual enrichment'.[82] If these ideals are to be pursued successfully, humans are required to abandon social ideals of cooperation and support. The consequence of asking one (the human need for social cooperation) to exist within the other ('minimally regulated competitive markets'[83]), is, according to Alexander's social dislocation theory, 'a general breakdown of psychosocial integration … producing mass dislocation in every stratum of world society'.[84]

Social exclusion is one key way in which the operation of the free market will cause a breakdown in psychosocial integration, leading to social dislocation.[85] Social exclusion has been summarised emotively by Wilkinson, who also provides a good picture of how it can result from intense free market competition between human beings:

> 'To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job and housing insecurity; to feel devalued, useless, helpless, uncared for, hopeless, isolated, anxious and a failure: these feelings can dominate people's whole experience of life … The material environment is merely the indelible mark and constant

[77] Alexander, n 75 above, 58.
[78] ibid.
[79] Alexander, n 75 above, 59.
[80] Alexander, n 75 above, 60.
[81] See Alexander's summary of the anthropological evidence: Alexander, n 75 above, 85-95.
[82] Alexander, n 75 above, 61.
[83] ibid.
[84] Alexander, n 75 above, 99.
[85] See for example: A Madanipour et al, *Social exclusion in European Cities: Processes, Experiences, and Responses* (London: Routledge 2000), 7.

> reminder of the oppressive fact of one's failure, of the atrophy of any sense of having a place in a community, and of one's social exclusion and devaluation as a human being'.[86]

The experience of social exclusion is therefore an important conduit through which free market competition creates the breakdown of psychosocial integration and the experience of social dislocation. Those who cannot keep up with the pace of competition – or are not in a position of advantage to be able to capitalise on what the market offers – are left behind by society, an outcome that is made more likely the more disadvantaged one is to begin with.[87] Social exclusion, while important, is not the only process that can lead to the breakdown of psychosocial integration though. Advantaged individuals are also at risk of developing addictions through a breakdown of psychosocial integration, for different reasons – for example, some have argued that factors such as pressure to achieve and isolation from parents may underpin a breakdown in psychosocial integration in children from affluent neighbourhoods.[88] These findings can just as plausibly be connected to the materialistic, competitive culture that is promoted by the free market.

Based upon the fact that free market competition can lead to the experience of social dislocation, Alexander's theory argues that individuals 'often adapt to the anguish of sustained dislocation by devoting themselves to narrow lifestyles that function as substitutes for psychosocial integration'.[89] Alexander identifies this narrow lifestyle as an addiction – addiction is therefore 'neither a disease nor a moral failure, but a narrowly focussed lifestyle that functions as a meagre substitute for people who desperately lack psychosocial integration'.[90] This theory finds support in the literature on negative affect and addiction – for example, Uusitalo and colleagues have argued that 'affect conspires with [an individual's] thinking and reasoning in support of choosing addictive behaviour'[91] where 'existing negative affects such as depression, anxiety, restlessness, irritability or shame raise the expected utility of behaviours that offer the agent an escape from the present misery'.[92] Addiction is therefore explained according to Alexander's theory as an adaptation – not a biological reaction, or a personality failure, but a behavioural response to maximise well-being and survival chances in circumstances of acute discomfort and adversity.

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[86] R Wilkinson, *Unhealthy societies: the afflictions of inequality* (London: Routledge 1996), 215.
[87] See for example: G Room, 'Social exclusion, solidarity and the challenge of globalization' (1999) 8(3)International Journal of Social Welfare 166.
[88] S Luthar, The culture of affluence: psychological costs of material wealth' (2003) 74(6) Child Development 1581.
[89] Alexander, n 75 above, 62.
[90] ibid.
[91] S Uusitalo et al, 'Addiction, agency and affects – philosophical perspectives' (2013) 30 Nordic Studies on Alcohol and Drugs 33, 40.
[92] ibid, 41.

Adaptation as a coping mechanism for social dislocation explains many of the curious features of addictive behaviour. It can explain why individuals cannot escape some addictions despite an intense desire to do so – if these individuals cannot build sufficient psychosocial integration, then 'without their addictions, they would have terrifyingly little reason to live'.[93] The converse of this also explains why addictions can suddenly be overcome, without any apparent outside intervention. The adaptation to dislocation theory explains why individuals can become addicted to substances or behaviours. It also explains why individuals who to all intents and purposes have wealthy, well-off lifestyles can develop addictions as easily as those living in poverty – adaptation to an addictive lifestyle can be both 'more sustaining than the unrelenting torment of social exclusion and aimlessness' and 'a sense of meaning for affluent [individuals] bereft of richer purposes'.[94] The theory also helps to explain why some people in stressful life circumstances do not develop an addiction, yet others do – 'only chronically and severely dislocated people are vulnerable to addiction'.[95]

The adaptation to dislocation theory has many advantages for explaining addiction, yet it too, by Alexander's admission, cannot explain every vagary of the addiction phenomenon. For example, it cannot explain why individuals suffering similar dislocation will turn to different addictive objects, or why similarly dislocated individuals may or may not find a way out of their addiction.[96] Just as the disease model could not explain why addictions develop, and the free will model could not explain how addictions develop, Alexander's social dislocation model raises further questions regarding the process of adaptation. How exactly do potential objects of addiction provide the adaptive relationship that a socially dislocated individual seeks? As West reminds us, no theory can fully explain the addiction phenomenon due to 'unavoidable ambiguities in many of the concepts and the difficulty in ruling out competing explanations'.[97] However, Alexander's theory can be developed in order to build a more complete picture of addiction. The next section therefore presents an expanded model for addiction development that attempts to accurately capture not just the nature of addiction, but the process through which it is developed.

[93] Alexander, n 75 above, 62.
[94] ibid.
[95] Alexander, n 75 above, 63.
[96] Alexander, n 75 above, 66-67.
[97] West, n 64 above, 6.

III. The addictiogenic environment – a modified social dislocation model of addiction

As Alexander explains, 'although only dislocated people become addicted, many severely dislocated people live and die in ways that cannot be called "addiction"'.[98] This section will argue that an expanded version of Alexander's social dislocation model – the *addictiogenic environment model* of addiction development – could potentially explain the circumstances in which the experience of dislocation is likely to lead to addiction.

Consider the existence of a specific set of environmental factors that promote, encourage and facilitate the development of addictions. This set of factors could be called the *addictiogenic environment*, and could be mapped to three basic elements of addiction development. One is social dislocation. The other two elements are the capacity to build pseudo-relationships, and the potential to engage in vocational consumption. The model, represented graphically in Figure 1 below, holds that if factors within an individual's environment are strong enough to promote their experience of social dislocation, encourage them to develop pseudo-relationships with potential objects of addiction, and facilitate their vocational consumption of such objects of addiction, an addiction is likely to be developed. All three elements – social dislocation, a pseudo-relationship, and the opportunity for vocational consumption – are necessary to the development of an addiction. The following sections present a more detailed explanation of the model.

[98] Alexander, n 75 above, 64.

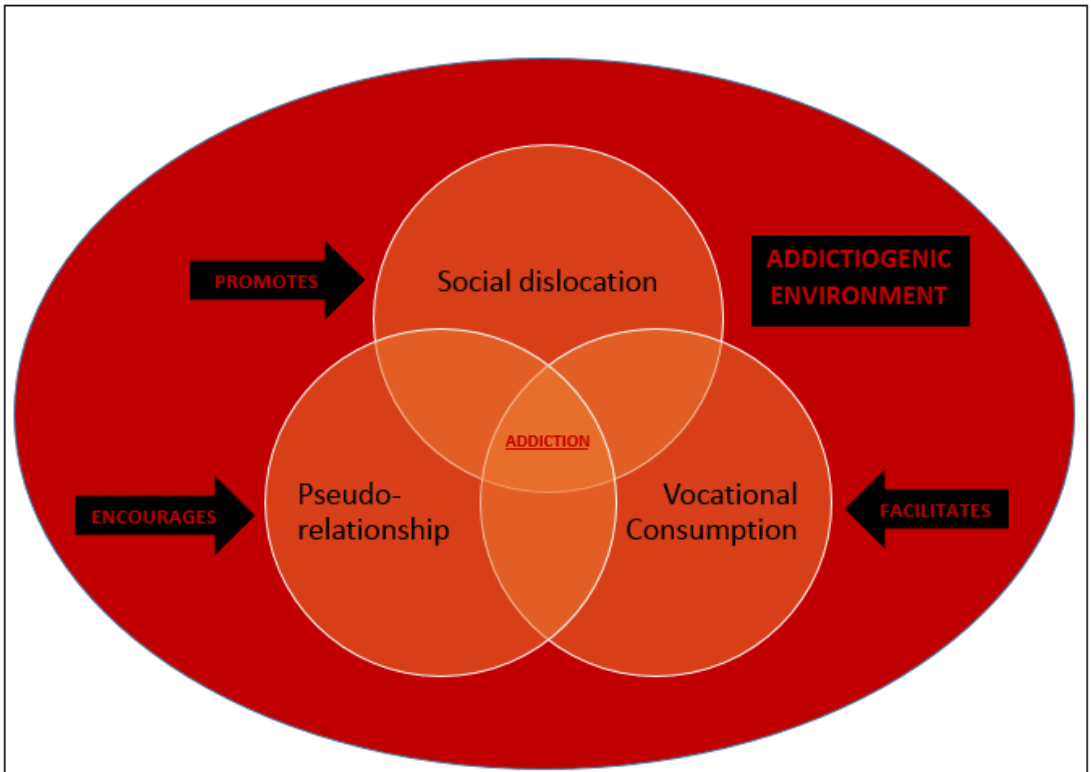

Figure 1: The Addictiogenic Environment

A. 'Promote factors' of the addictiogenic environment

The meaning of social dislocation was explained in detail above in the context of Alexander's theory. From the perspective of an addictiogenic environment model, certain specific factors within an individual's environment will actively *promote* the experience of social dislocation.

'Promote factors' of the addictiogenic environment are often found in poorly designed social institutions and support structures, which then foster unsupportive or stressful social environments that cause individuals to lose psychosocial integration, and potentially experience social dislocation.[99] For instance inequality in social support for minority groups, underdeveloped

[99] For evidence on the production of negative effect by environmental stimuli, see for example: N Volkow et al, 'Addiction: Pulling at the Neural Threads of Social Behaviours' (2011) 69(4) Neuron 599, 601; Adler et al, 'Relationship of Subjective and Objective Social Status With Psychological and Physiological Functioning: Preliminary Data in Healthy White Women' (2000) 19(6) Health Psychology 586; C Carver and M Scheier, 'Origins and Functions of Positive and Negative Affect: A Control-Process View' (1990) 97(1) Psychological Review 19.

understanding of and support for mental health illnesses,[100] and ineffective approaches in redeveloping deprived areas[101] all worsen what are already difficult circumstances to the point that they may become unbearable for the individual experiencing them. Further examples might include the way in which the social class hierarchy is perceived by individuals, which can lead to very low subjective perceptions of social standing, generating high levels of stress and negative psychological functioning.[102] Moreover, social protection structures that, for example, ensure that an individual has access to sufficient housing may, if organised poorly, actually reduce the level of control that people have over their lives, generating high levels of stress, which can lead to the loss of psychosocial integration and social dislocation.[103]

In general, as Marmot and colleagues put it, the fact that an individual's social environment could promote the experience of social dislocation, and the fact that these experiences are unequally distributed within the population, 'is not in any sense a natural phenomenon but is the result of a combination of poor social policies and programmes, unfair economic arrangements, and bad politics'.[104] The organisation of social structures and institutions in ways that do not generate opportunity and do not support vulnerable or excluded individuals, and the way in which social inequality amongst the population exacerbates this,[105] therefore must be seen as factors of an addictiogenic environment.

B. 'Encourage factors' of the addictiogenic environment

In addition to factors that promote social dislocation, the addictiogenic environment is also comprised of a group of factors that encourage the development of pseudo-relationships between socially dislocated individuals and potential objects of addiction. Individuals that are searching for a way to adapt to social dislocation are searching for some experience that will act as a 'partial substitute for the psychosocial integration that the addicted person has lost', and with which it is

[100] T Wykes et al, 'Mental health research priorities for Europe' (2015) 2(110 Lancet Psychiatry 1036.
[101] H Anderson, 'Can Deprived Housing Areas Be Revitalised? Efforts against Segregation and Neighbourhood Decay in Denmark and Europe' (2002) 39 Urban Studies 767.
[102] Adler et al, n 99 above, 590.
[103] See Fair Society, Health Lives (The Marmot Review), available at http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review (accessed 27 June 2015), 39.
[104] M Marmot et al, 'Closing the gap in a generation: health equity through action on the social determinants of health' (2008) 372 Lancet 1661, 1661.
[105] See: S Musterd and W Ostendorf, 'Segregation, polarisation and social exclusion in metropolitan areas' in S Musterd and W Ostendorf (eds), *Urban Segregation and the Welfare State: Inequality and exclusion in western cities* (Oxon: Routldege 1998), 2.

possible to develop a 'strong attachment'.[106] If an individual is able to form a pseudo-relationship with an object, a form of emotional bond that will provide 'some real psychosocial gratifications',[107] and to which they can dedicate a narrowly focussed lifestyle, an addiction to that object is likely to be formed.

Objects are likely to sustain a pseudo-relationship, for example, when engagement with them entails participation in some form of subculture or group consumption that provides opportunities for human interaction and a sense of belonging.[108] Objects are also likely to sustain pseudo-relationships if individuals feel that they can depend upon them or their effects whenever needed, in the face of the volatility of the rest of their life.[109] Objects whose use enables the initiation of the individual into a special 'language' of consumption, thus fostering a sense of ownership or specialness, will also be apt to sustain pseudo-relationships.[110] As a final example, objects will sustain pseudo-relationships if they project a sense of personality or emotional identity with which the individual wishes to associate.[111]

Accepting that individuals will seek to form pseudo-relationships with objects when they cannot establish sufficient human relationships, and that certain factors of an individual's environment will encourage the formation of such bonds, can help to add further depth to Alexander's social dislocation theory, providing a potential explanation for the mechanism through which an individual will adapt to a lifestyle of addiction. The pseudo-relationship, in short, provides the substitute emotional bond that individuals lose when they become socially dislocated.

'Encourage factors' of the addictiogenic environment are often the result of current policy approaches that do not carefully balance the potentially harmful nature of objects of addiction with their status as commodities.[112] Despite being abnormal goods or services, the trade in addictive objects is guided by the economic norms that apply to trade in every other good or service. As Sihto and colleagues explain, instead of integrating public health concerns into the making of policy on trade in addictive objects:

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[106] J Orford, 'Addiction as excessive appetite' (2001) 96 Addiction 15, 15.
[107] Alexander, n 75 above, 164.
[108] Alexander, n 75 above, 165.
[109] E Hirschman, 'The consciousness of addiction: toward a general theory of compulsive consumption' (1992) 19(2) The Journal of Consumer Research 155, 174.
[110] D Lombardi, 'The special language of the addict' (1969) 20 Pastoral Psychology 51.
[111] On the creation of positive emotions surrounding addictive objects, see for example: R Engels et al, 'Alcohol portrayal on television affects actual drinking behaviour' (2009) 44(3) Alcohol and Alcoholism 244.
[112] On the commodified nature of potential objects of addiction such as alcohol, see: T Babor et al, *Alcohol: No Ordinary Commodity* (Oxford University Press 2010).

> 'health policy priorities are dependent on broader priorities and aims of governments … the aims of enhancing competitiveness of the economy or priorities of trade and industry are often substantially higher … [which] has led to a situation where, rather than articulating how economic, industrial and trade policies could contribute to the health and well-being of European citizens, health policies … are scrutinized themselves in terms of their compliance with and contribution to industrial, trade and economic policies' [113]

Consequently, in most European countries public health concerns are not woven into the pursuit of all policy objectives, including those relating to trade in addictive objects. Even at EU level public health concerns are often secondary to economic concerns, despite the fact that 'mainstreaming' obligations exist at EU level, supposedly obliging the EU to ensure 'a high level of human health protection' in the 'definition and implementing of *all Union policies and activities*'.[114]

The result has been that addictive objects are treated as everyday commodities.[115] The marketplace has consequently normalised the consumption of objects of addiction by hiding potentially dangerous objects behind friendly consumer brands,[116] brands that individuals are then encouraged to connect with in their everyday lives.[117] The marketing and promotion of objects of addiction has served to enhance their emotional and relational characteristics,[118] turning potentially dangerous products and services into desirable products and services. Producers of objects of addiction sponsor events with high emotional appeal,[119] and advertisements play heavily upon various consumer aspirations,[120] in order to give such objects personality. Addictive objects are also physically

[113] M Sihto et al, 'Principles and challenges of Health in All Policies' in T Stahl et al (eds.), *Health in All Policies: Prospects and potentials* (European Observatory on Health Systems and Policies 2006), 10.
[114] Article 168(1), TFEU. Emphasis added.
[115] See again T Babor et al, 'Alcohol: No Ordinary Commodity – a summary of the second edition' (2010) 105 Addiction 769.
[116] G Hastings, 'Why corporate power is a public health priority' (2012) 345 British Medical Journal e5124, e5124.
[117] S Hurtz et al, 'The relationship between exposure to alcohol advertising in stores, owning alcohol promotional items, and adolescent alcohol use' (2007) 42(2) Alcohol and Alcoholism 143.
[118] See for example: S Casswell, 'Alcohol brands in young peoples' everyday lives: new developments in marketing' (2004) 39(6) Alcohol and Alcoholism 471; R Buck and W Davis, 'Marketing risk: emotional appeals can promote the mindless acceptance of risk' in S Roeser (ed) *Emotions and Risky Technologies* (Springer 2010).
[119] A Maher et al, 'Patterns of sports sponsorship by gambling, alcohol and food companies: an Internet survey' (2006) 6 BMC Public Health 95; G Hastings, "*They'll drink bucket loads of the stuff"; an analysis of internal alcohol industry advertising documents* (The Alcohol Education and Research Council 2009), 31.
[120] For example, see the findings of the final report of the AMMIE project: *Commercial promotion of drinking in Europe: Key findings of independent monitoring of alcohol marketing in five European countries* (Dutch

designed to maximise their emotive properties. For example, electronic gambling machines are meticulously designed to offer a familiar and dependable bubble of escapism to gamblers, in order to mask the fact electronic gambling machines offer incredibly poor odds to players.[121] Messages about the consumption of addictive objects have even become embedded in cultural pursuits.[122]

The consequence is that the appeal and acceptability of potential objects of addiction is increased, along with the emotional and relational characteristics of such objects. This in turn increases the likelihood than an individual will be able to form a pseudo-relationship with those objects. Policymaking that creates conditions in which the market can turn commodities into objects of addiction that dislocated individuals would want to emotionally bond with must therefore be seen as factors of the addictiogenic environment.

C. 'Facilitate factors' of the addictiogenic environment

In addition to factors that promote social dislocation and encourage the formation of pseudo-relationships, the addictiogenic environment is made up of one final group of factors. These factors facilitate vocational consumption of objects of addiction. Vocational consumption can be understood as just that – consumption that, for an individual, becomes their vocation. Individuals with functioning social bonds may choose to dedicate themselves to a variety of vocations – careers, hobbies, raising families, or looking after loved ones. When an individual is unable to form functioning relationships, and must adapt to a narrower lifestyle that is focussed upon a pseudo-relationship with an object of addiction, the vocations that such individuals might devote themselves to become very limited in number. Consumption of their object of addiction becomes the primary vocation that an addicted individual feels able to dedicate themselves to. Such a vocation will enable them to engage in their pseudo-relationship on a regular basis, and to avoid having to face the reality of their social dislocation.

In such a situation, consumption should be described as not just heavy, but vocational. Vocational consumption of an object is not a natural state of affairs, and if vocational consumption is to be sustainable, it must be facilitated by an individual's environment. As Larkin et al note, 'the

Institute for Alcohol Policy 2012) available online at http://eucam.info/wp-content/uploads/2014/04/ammie-eu-rapport_final.pdf (last accessed 29 July 2016). See also: Hurtz et al, n 117 above.

[121] See: N Schüll, *Addiction by design: Machine gambling in Las Vegas* (Princeton University Press 2012).

[122] S Stern, 'Messages from Teens on the Big Screen: Smoking, Drinking and Drug Use in Teen-Centred Films' (2005) 10(4) Journal of Health Communication 331.

importance of context'[123] is key in the development of addictive relationships. For example, individuals feel able to engage with their object vocationally when engagement per se with that object is considered a normal social activity.[124] Furthermore, where those visibly in treatment for an addiction are stigmatised more than those not in treatment, the social incentive for addicted individuals to simply dedicate themselves to their pseudo-relationship, rather than attempt to leave it, is magnified.[125] The extent to which resources that permit focussed and dedicated engagement with a particular object of addiction are available to an individual also determines the extent to which vocational consumption is possible.[126]

'Facilitate factors' of the addictiogenic environment are therefore usually connected to policymaking that promotes 'unfettered production, trade and consumption'[127] of potential objects of addiction and 'tolerance of a retail environment'[128] for such objects, thus allowing the market to increase opportunities for consumption as much as possible, providing the space and resources that could sustain vocational consumption. Studies show that a high proportion of revenue generated by the consumption of potential objects of addiction comes from the heaviest users,[129] so when economic operators are given little incentive not to target such consumers, it is inevitable that environments facilitating vocational consumption will thrive.

The result is an environment in which it is relatively easy for an individual to devote themselves to a vocation of consuming their preferred object of addiction. When the price of addictive objects is low[130] and the abundance of deals and offers encourages buying in bulk, when the distance individuals have to travel to acquire addictive objects is short,[131] and when the hours of the day

[123] M Larkin et al, 'Towards addiction as relationship' (2006) 14(3) Addiction Research and Theory 207, 211.
[124] See, for example: S Monaghan et al, 'Impact of gambling advertisements and marketing on children and adolescents: Policy recommendations to minimise harm' (2008) 22 Journal of Gambling Issues 252, 254; M Hellman, 'From myth of marginality to portrayals of an addictive society: Reporting on addictions in the Finnish press (1968–2006)' (2010) 18(2) Addiction Research and Theory 224.
[125] R Room, 'Stigma, social inequality and alcohol and drug use' (2005) 24 Drug and Alcohol Review 143, 152.
[126] Reith, n 50 above, 287-288.
[127] Marmott et al, n 104 above, 1665.
[128] J Cohen and L Anglin, 'Outlet density: a new frontier for tobacco control' (2009) 104(1) Addiction 2, 2
[129] In the gambling context, for example, a study found that in Ontario in 2003, problem gamblers accounting for less than 5% of the population accounted for over a third of total revenue: R Williams and R Wood, 'The proportion of Ontario gambling revenue derived from problem gamblers' (2007) 33(3) Canadian Public Policy 367.
[130] G Becker et al, 'Rational Addiction and the Effect of Price on Consumption' (1991) 81(2) The American Economic Review 237.
[131] J West et al, 'Does Proximity to Retailers Influence Alcohol and Tobacco Use Among Latino Adolescents?' (2010) 12(5) Journal of Immigrant and Minority Health 626.

during which individuals can access their preferred objects of addiction are extensive,[132] there is little impediment to vocational consumption. At the extreme end of the scale, governments even condone consumption of addictive objects and provide the space in which individuals can devote themselves to consumption without fear of societal condemnation. State-run lotteries for example are common throughout Europe, and are actively promoted by governments or their agents, with the UK Government even introducing a National Lottery in 1994 with the argument that it was 'not a real form of gambling because it was for good causes'.[133] Lottery gambling, however has since been shown to be a potentially harmful object of addiction.[134] In summary then, policymaking that permits the market to maximise the ease with which addictive objects may be consumed vocationally should be considered a final group of factors of the addictiogenic environment.

V. Conclusion - Tackling Europe's addictiogenic environment.

This chapter has established that addiction is a phenomenon generated by an addictiogenic environment that promotes social dislocation, encourages the development of pseudo-relationships, and facilitates vocational consumption. Clearly, in order to reduce the prevalence of addiction, it will be necessary to reduce the strength of the addictiogenic environment by controlling the factors that comprise such an environment.

However, as Alexander observed when setting out his theory of adaptation to dislocation, the globalisation of free market ideals is now entrenched to the point that such ideals would be very difficult, if not impossible, to change.[135] For this reason, society will always suffer addiction to at least some degree – Alexander's theory holds that addiction is a natural consequence of free market competition, so therefore as long as free market competition persists, addiction will persist. Finding a perfect solution that eradicates all risks of addiction development is therefore not possible.

Having said this, the strength of the addictiogenic environment will vary depending on how well its constituent factors are controlled – anything above a very weak addictiogenic environment must be considered as producing preventable levels of addiction. It is arguable that a strong addictiogenic

[132] Þorgerður Ragnarsdóttir et al, 'Effect of extended alcohol serving-hours in Reykjavik' in R Room (ed), *The Effects of Nordic Alcohol Policies: What happens to drinking and harm when alcohol controls change?* (Nordic Council for Alcohol and Drug Research: Helsinki, 2002).
[133] M Griffiths and R Wood, 'Lottery gambling and addiction: An overview of European research' (2002) available online at https://www.e-stave.com/documents/odgovorno-igranje/Lottery-gambling-and-addiction-(EU%20research)-Mark-Griffiths.pdf, 2.
[134] Ibid.
[135] Alexander, n 75 above.

environment currently exists in Europe, since a lack of control of many of the factors identified above is evident. For example, social exclusion and social inequality is widespread throughout European society.[136] Marketing controls currently do not prohibit advertising from playing on emotions, and often cannot prevent associations being made by advertising that are in fact prohibited from being made.[137] The density of retail outlets for alcohol, unhealthy food and gambling, for example, is high, especially in disadvantaged areas.[138] Rates of tax applied to alcohol, for example, have decreased in real terms across the European Union over the last two decades.[139] It is therefore reasonable to argue that the addictiogenic environment is currently strong in Europe – weakening it will require focused and evidence-based interventions to control the factors of this environment. The next chapter considers the justification for using legal tools in order to provide this control.

[136] J Siegrist and M Marmot (eds), *Social inequalities in Health: New Evidence and Policy Implications* (Oxford University Press 2006); Marmot et al, n 104 above; M Marmot et al, 'WHO European review of social determinants of health and the health divide' (2012) 380(9846) Lancet 1011; R Wilkinson and M Marmot, *Social Determinants of Health: The Solid Facts* (World Health Organization 2003).

[137] *Commercial promotion of drinking in Europe,* n 120 above; *First Report from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on the application of Directive 2010/13/EU "Audiovisual Media Service Directive"*, COM(2012) 203 final, 7.

[138] J Holmes et al, 'The impact of spatial and temporal availability of alcohol on its consumption and related harms: a critical review in the context of UK licensing policies' (2014) 33(5) Drug and Alcohol Review 515; A Lake and T Townshend, 'Obesogenic environments: exploring the built and food environments' (2006) 126(6) Perspectives in Public Health 262; H Wardle, '"Risky Places?": Mapping gambling machine density and socio-economic deprivation' (2014) 30 Journal of Gambling Studies 201.

[139] S Cnossen, 'Alcohol taxation and regulation in the European Union' (2007) 14(6) International Tax and Public Finance 699, 703.

CHAPTER THREE – THE NORMATIVE CASE FOR INTERVENTION

I. Introduction

So far, this thesis has argued that addiction may be explained by an addictiogenic environment model, and that the addictiogenic environment is responsible for promoting, encouraging and facilitating the development of addictions. It seems natural to presume that intervention by public authorities to control the factors of the addictiogenic environment would therefore be desirable, given the scale of the public health and social problem that addiction generates. However, shaping the social environment in order to achieve public health or social goals is not a costless activity. This chapter therefore seeks to make the case for why control of the addictiogenic environment through legal intervention *should* be pursued.

The chapter will argue that law is an essential tool of addiction policy, yet that serious objections to the use of law in achieving public health and social goals can be raised. Legal intervention to control the factors of the addictiogenic environment must therefore be normatively justified, if it is to be legitimate. After presenting the normative case against legal intervention, two normative cases for intervention will be presented. The first is that the existence of a right to health in international law provides a rights-based justification for the Member States and the EU to do all they can to weaken the strength of the addictiogenic environment. The second is that the principles of social justice and stewardship provide ethical justification for public authorities to use the powers delegated to them to do the same.

II. Law as a tool of addiction policy

Law could be a crucial tool of addiction policy, since law is one of the fundamental ways in which governments and other public authorities can shape the social environment.[140] Gostin summarises

[140] M Mello et al, 'Obesity – The new frontier of public health law' (2006) 354 New England Journal of Medicine 2601, 2608.

the potential of law for shaping the public health environment as follows: 'statutes, regulations and litigation can be pivotal tools for creating the conditions for people to lead healthier and safer lives'.[141] Consequently, strong and evidence-based legal intervention is one of the most effective ways in which the factors of the addictiogenic environment could be controlled so that they no longer push individuals suffering hardship into a life of addiction.

There are a number of ways in which law can achieve this.[142] For example: certain behaviours can be encouraged or discouraged through the use of taxation and other economic incentives and disincentives;[143] standards of quality for goods and services can be set, and the very goods and services that individuals are exposed to can be altered, through the use of product regulation[144] or trade rules;[145] the level of support that individuals can seek from the state can be defined through the rules governing access to social support and welfare funds;[146] even the way in which we choose to engage with addictive objects can be guided, through the use of nudges[147] or the demarcation of social space.[148]

Evidence shows that certain legal tools are particularly effective in controlling important factors of the addictiogenic environment. Price is strongly linked to levels of consumption – by raising the price of addictive objects and therefore lowering their affordability and accessibility, taxation has proved to be a very effective method of reducing consumption of many objects of addiction such as alcohol,[149] tobacco[150] and sugary foodstuffs.[151] Taxation is not the only form of economic

[141] L Gostin, 'Public health law in a new century. Part I: Law as a tool to advance the community's health' (2000) 283 Journal of the American Medical Association 2837, 2837.
[142] For an overview of the legal toolkit that public health policymakers have access to, see: A Alemanno and A Garde, 'The emergence of an EU lifestyle policy: The case of alcohol, tobacco and unhealthy diets' (2013) 50 Common Market Law Review 1745.
[143] F Sassi et al, 'Taxation and economic incentives on Health-related commodities: Alcohol, tobacco and food'' in A Alemanno and A Garde (eds), *Regulating Lifestyle Risks: The EU, Alcohol, Tobacco and Unhealthy Diets* (Cambridge University Press 2015).
[144] L Deyton et al, 'Tobacco product regulation – a public health approach' (2010) 362 New England Journal of Medicine 1753.
[145] K Fagerstrom and E Schildt, 'Should the European Union lift the ban on *snus*? Evidence from the Swedish experience' (2003) 98(9) Addiction 1191.
[146] J Kullgren, 'Restrictions on undocumented immigrants' access to health services: the public health implications of welfare reform' (2003) 93(10) American Journal of Public Health 1630.
[147] A Alemanno and A Sibony, *Nudge and the Law: A European Perspective* (Oxford: Hart 2015).
[148] C Fichtenberg and S Glantz, 'Effect of smoke-free workplaces on smoking behaviour: systematic review' (2002) 325 British Medical Journal 188.
[149] R Elder et al, 'The effectiveness of tax policy interventions for reducing excessive alcohol consumption and related harms' (2010) 38(2) American Journal of Preventive Medicine 217.
[150] F Chaloupka et al, 'Effectiveness of tax and price policies in tobacco control' (2010) Tobacco Control DOI:10.1136/tc.2010.039982.
[151] K Brownell et al, 'The public health and economic benefits of taxing sugar-sweetened beverages' (2009) 361 New England Journal of Medicine 1599.

disincentive that can reduce the affordability of addictive objects though – when a more precise intervention is desired, minimum pricing has proved to be effective in reducing the affordability of the specific types of addictive object that are commonly consumed vocationally.[152]

The marketing of objects of addiction has also been linked convincingly to the level at which those objects are consumed.[153] By controlling the marketing of objects of addiction, alcohol for instance, the ability of the object to sustain pseudo-relationships will be greatly reduced. Evidence has linked the extent to which alcohol advertising is liked or enjoyed to the extent of consumption.[154] This suggests that if advertising for addictive objects is controlled in such a way as to remove creative elements that generate liking or enjoyment, or if advertising is banned altogether, consumption will be reduced. In general, evidence suggests that advertising controls are effective in reducing consumption for a range of addictive objects, such as tobacco,[155] alcohol,[156] gambling[157] and unhealthy foods.[158] Since direct advertising is not the only way in which an object of addiction can be marketed, further legal controls have been devised, and have been effective in reducing the appeal of addictive objects and their consumption – for example point of sale display bans,[159] and plain packaging of cigarettes.[160]

The built environment is another major influence on the availability and accessibility of objects of addiction. Evidence demonstrates that if an area has a particularly high number of retail outlets for an object of addiction, gambling services for example, the high the consumption of that object will

[152] T Stockwell et al, 'Does minimum pricing reduce alcohol consumption? The experience of a Canadian province' (2012) 107(5) Addiction 912.
[153] L Smith and D Foxcroft, 'The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies' (2009) 9 BMC Public Health 51; P Anderson et al, 'Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies' (2009) 44(3) Alcohol and Alcoholism 229.
[154] E Weintraub, 'How does alcohol advertising influence underage drinking? The role of desirability, identification and skepticism' (2006) 38(4) Journal of Adolescent Health 376; S Casswell and J Zhang, 'Impact of liking for advertising and brand allegiance on drinking and alcohol-related aggression: a longitudinal study' (1998) 93(8) Addiction 1209.
[155] P Jha, Reducing the burden of smoking world-wide: effectiveness of interventions and their coverage' (2006) 25(6) Drug and Alcohol Review 597.
[156] P Anderson et al, 'Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol' (2009) 373(9682) Lancet 2234.
[157] Monaghan et al, n 124 above.
[158] A Magnus, 'The cost-effectiveness of removing television advertising of high-fat and/or high-sugar food and beverages to Australian children' (2009) 33 International Journal of Obesity 1094.
[159] A McNeill et al, 'Evaluation of the removal of point-of-sale tobacco displays in Ireland' (2010) Tobacco Control doi:10.1136/tc.2010.038141.
[160] B Freeman et al, 'The case for the plain packaging of tobacco products' (2008) 103(4) Addiction 580.

be in that area.[161] Since a high level of access to addictive objects is a factor that will increase opportunities for vocation consumption, controlling the physical availability of addictive objects through regulation of the built environment appears to be an effective way of controlling that factor.[162] Furthermore, evidence also suggests that economic operators will specifically open retail outlets in areas of high market demand, which tend to also be more disadvantaged neighbourhoods.[163] Thus controlling the placement of retail outlets appears to be an effective way of preventing economic operators from targeting communities in which individuals are more vulnerable to being pushed into addictions.[164]

The factors of the addictiogenic environment do not merely consist of the activities of economic operators and the attractiveness and availability of objects of addiction. The extent to which social structures promote the development of social dislocation is a crucial part of the addictiogenic environment, and a factor that legal intervention could also help to control. Evidence suggests that addictions are often comorbid with mental illnesses for example.[165] Following the addictiogenic environment model of addiction development, individuals with mental illnesses may develop addictions as a result of exclusion or stigma that they have suffered on account of their illness, a process which may even be systematically entrenched.[166] Legal interventions can help to address systematic exclusion of individuals in vulnerable positions, such as those suffering mental illnesses, by mandating a certain level of institutional support that is to be provided to such individuals.[167]

[161] J Pearce, 'A National study of neighbourhood access to gambling opportunities and individual gambling behaviour' (2008) 62 Journal of Epidemiology and Community Health 862; S Vasiliadis et al, 'Physical accessibility of gaming opportunity and its relationship to gaming involvement and problem gambling: a systematic review' (2013) 28 Journal of Gambling Issues 1.

[162] D Marshal, 'Gambling as a public health issue: The critical role of the local environment' (2009) 23 Journal of Gambling Issues 66.

[163] C Morrison, 'Socioeconomic determinants of exposure to alcohol outlets' (2015) 76(3) Journal of Studies on Alcohol and Drugs 439; D Gorman and P Speer, 'The concentration of Liquor outlets in an economically disadvantaged city in the northeastern United States' (1997) 32(14) Substance Use and Misuse 2033.

[164] For a discussion of outlet density control in the context of unhealthy foods and obesogenic environments, see: P Day and J Pearce, 'Obesity-promoting food environments and the spatial clustering of food outlets around schools' (2011) 40(2) American Journal of Preventive Medicine 113.

[165] Dani and Harris, n 31 above; D Regier et al, 'Comorbidity of mental disorders with alcohol and other drug abuse. Results from the epidemiologic catchment area (ECA) study' (1990) 264(19) Journal of the American Medical Association 2511; J Hyan Ha, 'Psychiatric comorbidity assessed in Korean children and adolescents who screen positive for internet addiction' (2006) 67(5) Journal of Clinical Psychiatry 821.

[166] See for example: J Leff and R Warner, *Social Inclusion of People with Mental Illness* (Cambridge University Press 2006), 5.

[167] G Thornicroft et al, 'Reducing stigma and discrimination: candidate interventions' (2008) 2 International Journal of Mental Health Systems 3; H Saffer and D Dave, 'Mental illnesses and the demand for alcohol, cocaine and cigarettes' (2005) 43(2) Economic Inquiry 229.

Shaping the environment in the ways outlined above may result in a significant weakening of the addictiogenic environment. However, the fact remains that shaping the environment through law is often a coercive process,[168] which is prone to 'intrude on individual rights and interests and incur economic costs'.[169] Furthermore, 'by espousing controversial issues of economic redistribution and social restructuring, the field [of addiction policy in particular] becomes highly political'.[170] Consequently, there will always be objections to the use of law as a tool of addiction policy. Many objections are made on the grounds that legal intervention in individual lifestyles is an unwarranted and unjustifiable intrusion into individual choice.[171] It is argued that government paternalism is unjustified on the basis that governments have little or no right to make lifestyle choices on behalf of individuals.[172] Furthermore, legal intervention is objected to on the basis that it infringes cultural sensitivities and fundamental rights.[173] As Martin notes, laws that seek to improve public health therefore 'must, like other public actions, be challengeable by individuals on human rights grounds'.[174] Economic operators also argue against legal control of their activities on the basis that they pose no threat to health. As Rothstein notes, 'without a threat to the public, it is much more difficult to make a case for the use of coercive powers',[175] and addiction industries have mobilised on a large scale to discredit and denounce any evidence or suggestion that their products or activities cause harm, and therefore require legal regulation.[176]

These objections to the use of law in order to shape environments are not to be taken lightly. Controlling the factors of the addictiogenic environment through law involves addressing sensitive issues of health, wellbeing and social inclusion – ineffective or badly made policy choices could

[168] D Wikler, 'Coercive measures in health promotion: can they be justified?' (1978) 6(2) Health Education and Behaviour 223.
[169] L Gostin, 'Public Health Law in a New Century: Part III: Public Health Regulation: A Systematic Evaluation' (2000) 283(23) Journal of the American Medical Association 3118, 3118.
[170] L Gostin, 'Public health, ethics, and human rights: A tribute to the late Jonathan Mann' (2001) 21 Journal of Law, Medicine and Ethics 121, 123.
[171] D Friedman, 'Public Health regulation and the limits of paternalism' (2014) 46(5) Connecticut Law Review 1687.
[172] See for example: L Wiley et al, 'Who's your nanny?: Choice, Paternalism and Public Health in the age of personal responsibility' (2013) 41(s1) Journal of Law, Medicine and Ethics 88.
[173] See for example the issues of addiction interventions and individual rights discussed in: E Nilssen and R Lien, 'Individual rights and collective obligation. Compulsory intervention towards substance abusers in Norwegian social law' (1999) 8(3) International Journal of Social Welfare 181.
[174] R Martin, 'Law as a tool in promoting and protecting public health: always in our best interests?' (2007) 121 Public Health 846, 852.
[175] M Rothstein, 'Rethinking the meaning of public health' (2002) 30 Journal of Law, Medicine and Ethics 144, 146.
[176] K Brownell and K Warner, 'The perils of ignoring history: Big tobacco played dirty and millions died. How similar is big food?' (2009) 87(1) The Millbank Quarterly 259.

generate highly negative outcomes that may eventually cost lives rather than save them.[177] The ethical implications of such negative outcomes are amplified when the policies that generated them have removed choice from those they apply to. The use of law as a tool of addiction policy therefore must be justified if it is to be legitimate. Two justifications are presented below. First, the use of law is justified because governments must comply with obligations generated by the right to health. Second, the use of law is justified by the pursuit of social justice and stewardship principles in the discharge of public authority.

III. Rights-based justification – the right to health

A. Introduction

A human right to health was first recognised in the 1946 Constitution of the World Health Organization,[178] followed two years later by recognition in the 1948 Universal Declaration of Human Rights.[179] While these constituted strong rhetorical statements of the standard to health that every individual should be entitled to, they have no formal legal force,[180] and therefore cannot be relied upon as rights-based justification for the use of law to control factors of the addictiogenic environment.

The first legally binding statement of the right to health was made in the International Covenant on Economic, Social and Cultural Rights (ICESCR),[181] adopted in 1966 and in force in 1976. Article 12 of the ICESCR states that:

[177] On the impact of interventions that are designed without due regard to epidemiological evidence, see: N Gill and M Gill, 'The limits to libertarian paternalism: Two new critiques and seven best-practice imperatives' (2012) 30 Environment and Planning C: Government and Policy 924. On the impact of interventions that are designed without due regard to fundamental rights, see: L Gostin and J Mann, 'Towards the development of a human rights impact assessment for the formulation and evaluation of public health policies' (1994) 1(1) Health and Human Rights 58.

[178] Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[179] Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217 A(III).

[180] See: F Grad, 'The Preamble of the Constitution of the World Health Organization' (2002) 80(12) Bulletin of the World Health Organization 981, 981; H Hannum, 'The status of the Universal Declaration of Human Rights in national and international law' (1995) 25 Georgia Journal of International and Comparative Law 287, 317.

[181] International Covenant on Economic, Social and Cultural Rights, 16 December 1977, United Nations, Treaty Series, vol 993, p. 3.

> 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.

Unlike the WHO Constitution and the UDHR, Article 12 of the ICESCR does generate binding legal obligations on all State parties – and at present all Member States are parties to the ICESCR. Article 12 is supported by General Comment 14 of the Economic and Social Committee, a document that interprets the content and scope of the obligations and responsibilities that the ICESCR places upon State and non-State actors alike.

Although the EU itself is not a party to the ICESCR, it can be argued that the EU should nonetheless be committed to upholding the principles that Article 12 embodies. Ahmed and de Jesus Butler argue that the EU is bound as a result of the EU Treaties and customary international law to respect and uphold the obligations that its Member States incur under human rights treaties they have entered into.[182] Even if the ICESCR cannot be deemed to indirectly bind the EU in this way, in 2009 the Charter of Fundamental Rights of the European Union (CFREU) became binding upon the EU institutions, and Article 35 CFREU provides that:

> 'Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities'.[183]

The EU is therefore bound by the Charter to uphold the right to health. As Kenner notes, the 'Charter carries with it a deep political desire to give resonance to the values that it propounds', and should be 'understood as part of a much broader fundamental rights dialogue'.[184] Peers et al further note that the ICESCR is one of the international law sources for Article 35 CFREU.[185] Moreover, as the CJEU acknowledged in their *Deutsches Weintor* judgement, an alcohol control intervention adopted 'in view of the risks of addiction and abuse as well as the complex harmful effects known to be

[182] T Ahmed and I de Jesus Butler, 'The European Union and Human Rights: An International Law Perspective' (2006) 17(4) The European Journal of International Law 771.
[183] Article 35, Charter of Fundamental Rights of the European Union, OJ C 326, 26.10.2012, 391.
[184] J Kenner, 'Economic and social rights in the EU legal order: the mirage of indivisibility' in T Hervey and J Kenner (eds), *Economic and Social Rights Under the EU Charter of Fundamental Rights: A Legal Perspective* (Oxford: Hart 2003), 4.
[185] S Peers et al (eds), *The EU Charter of Fundamental Rights: A Commentary* (Oxford: Bloomsbury Publishing 2014), 953.

linked to the consumption of alcohol'[186] should be 'regarded as being necessary to ensure compliance with the requirements that stem from Article 35 of the Charter'.[187] Drawing these facts together, it is possible to argue that the version of the right to health proclaimed in the CFREU has the same normative essence as the right to health proclaimed in the ICESCR, and that therefore there is reason for EU policymakers to take account of the obligations that are generated by Article 12 ICESCR.

The argument to be developed by the first half of this chapter is therefore that the obligations generated by the ICESCR (and echoed in the CFREU) to uphold the right to health justify the control of factors of the addictiogenic environment through legal intervention. The first stage in making this argument is to establish whether the right to health actually conveys protection on individuals against factors of the addictiogenic environment, and to what extent. The subsection below will therefore focus on the content of Article 12 ICESCR.

B. Addictiogenic environment content of the right to health.

Article 12 itself is quite vague. The meaning of a 'right to health' is not immediately apparent, nor is the answer to how a right to health is supposed to provide individuals with guarantees of protection against the addictiogenic environment. An examination of the basic nature of the right to health is therefore required.

i. What does the 'right to health' mean?

Having a right to something that cannot be tangibly identified and acted upon is worthless. As Hessler and Buchannan point out, the problem with having a right to 'health' is that 'it seems too demanding … a right to health seems to imply a right to be healthy, which is an impossible standard'.[188] The meaning of 'health' must therefore be established with more precision, to ensure that the right to health does not become an 'unobtainable ideal'.[189]

There is unfortunately no universally accepted definition of 'health'. The World Health Organization Constitution defines it as 'a state of complete physical, mental and social well-being and not merely

[186] Case 5-544/10 *Deutsches Weintor* [2012] ECLI:EU:C:2012:526, para 48.
[187] ibid, para 53.
[188] K Hessler and A Buchanan, 'Specifying the content of the human right to health care' in R Rhodes et al (eds.) *Medicine and Social Justice: Essays on the distribution of health care* (Oxford University Press 2002), 85.
[189] S Jamar, 'The International human right to health' (1994) 22(1) Southern University Law Review 1, 9.

the absence of disease of infirmity'.[190] This definition simply leaves us with the same problem though, as 'well-being' is just as vague a term as 'health'.[191] Indeed, the ICESCR drafting process rejected a suggestion to include the WHO definition of health in Article 12 due, amongst other things, to the fact that the 'reference to social well-being was out of place'.[192] The Ottawa Charter[193] also makes an effort to explain what 'health' entails, stating that health is 'a resource [for] everyday life, not the objective of living. Health is a positive concept, emphasizing social and personal resources, as well as physical capacities'.[194] This is hard to disagree with, but sheds no further light upon what 'health' means, only why health is essential.

Thus, 'health' cannot easily be defined, making it a difficult subject for a human right. General Comment 14 resolves this difficultly by making it clear that the right to health should not be conceptualised as a guarantee of good health. As literature points out, trying to guarantee such a complex state of being through human rights norms would be 'absurd'[195] due to the difficulties in identifying what 'health' is and therefore what one is entitled to. Instead, as General Comment 14 summarises, the right to health is a right 'to the enjoyment of a variety of facilities, foods, services and conditions necessary for the realization of the highest attainable standard of health'.[196]

Guaranteeing the provision of conditions in which individuals can seek to be as healthy as they possibly can is a far more attainable objective. Such a goal suggests that the subject of the right to health is access to the underlying determinants of health, rather than a nebulous concept of 'good health'. It is far easier to identify these determinants – the Ottawa Charter for example outlines that 'fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity'.[197] Most of these are tangible

[190] Preamble to the Constitution of the World Health Organization, n 178 above.
[191] See criticism by: E Kinney and B Clark, 'Provisions for health and health care in the constitutions of the countries of the world' (2004) 37 Cornell International Law Journal 285, 289; J Tobin, *The Right to Health in International Law* (Oxford University Press 2012), 125
[192] *Annotations on the text of the draft International Covenants on Human Rights* (1955) United Nations General Assembly, Document A/2929 111.
[193] A document 'adopted by a group of researchers, policy-makers and public health practitioners … as a road map for the countries involved in the WHO EURO region for pursuing the Declaration of Alma Ata's vision of "Health for All by the Year 2000": L Potvin and C Jones, 'Twenty-five years after the Ottowa Charter: The critical role of health promotion for public health' (2011) 102(4) Canadian Journal of Public Health 244, 244.
[194] *Ottawa Charter for Health Promotion* (Geneva, Switzerland: World Health Organisation Europe November 21 1986), available online at http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html (last accessed 9 June 2016).
[195] V Leary, 'The right to health in international human rights law' (1994) 1(1) Health and Human Rights 24, 28.
[196] General Comment 14 of the Economic and Social Council, The right to the highest attainable standard of health, 08/11/2000, E/C.12/2000/4. (General Comments), para 9.
[197] *Ottawa Charter for Health Promotion* n 194 above.

objects or conditions that are possible to secure through public action. Thus, to guarantee a right to health is to guarantee access to the *conditions* that allow individuals to pursue the best level of health they can attain. Upon this understanding, this subsection will now consider whether the absence of a strong addictiogenic environment is part of this set of conditions.

ii. Does the right to health guarantee the right to the absence of a strong addictiogenic environment?

In order to uncover whether the absence of a strong addictiogenic environment is included in the conditions that are guaranteed by the right to health, we must first understand how the substantive content of the right to health is organised. According to General Comment 14, the conditions necessary for pursuit of the highest attainable level of health can be organised into four groups – availability, accessibility, acceptability, and quality. Guaranteeing availability means ensuring that public health and health care facilities, services and goods are sufficiently plentiful.[198] Guaranteeing accessibility means ensuring that public health facilities, services and goods are accessible to everyone on equal terms.[199] Guaranteeing acceptability means ensuring that public health facilities, services and goods are ethically and culturally appropriate for all.[200] Finally, guaranteeing quality means ensuring that public health facilities, services and goods are scientifically and medically acceptable and of good quality.[201]

Guarantees of the availability, accessibility, acceptability and quality of the conditions necessary for pursuit of the highest attainable standard of health can be of two types – freedoms or entitlements. According to General Comment 14, freedoms are any guarantee that relates to control of one's own health and body, while entitlements are any guarantee that relates to a system of health protection that provides equality of opportunity to attain the highest possible standard of health.[202] A series of more specific guarantees are made by Article 12 in relation to certain population sub-groups, which are also elaborated on by General Comment 14.[203]

An analysis of General Comment 14 shows that this framework of freedoms and entitlements on the availability, accessibility, acceptability and quality of the conditions necessary for pursuit of the highest attainable standard of health should encompass the absence of a strong addictiogenic

[198] General Comment 14 n 196 above, para 12(a).
[199] ibid, para 12(b).
[200] ibid, para 12(c).
[201] ibid, para 12(d).
[202] ibid, para 8.
[203] Ibid, paras 18-27.

environment. Firstly, there are direct references to potential objects of addiction - the right to 'the improvement of all aspects of environmental and industrial hygiene'[204] as set out in Article 12(2)(b) 'discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances'.[205] There are also references that plausibly cover the factors of the addictiogenic environment – 'the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health'.[206] Since addiction is a life adaptation that often leads to serious negative health consequences, any factors that increase the likelihood of developing an addiction must be deemed to fall within the scope of this 'wide range'.

General Comment 14 also remarks that 'there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible'.[207] Some factors of the addictiogenic environment could easily be described as retrogressive – for instance the promotion of addictive objects through the organisation of state-run lotteries, or the frustration of effective addiction policies through deliberate obfuscation of evidence.[208] Avoiding retrogressive action on the determinants of health should include the elimination of practices such as these that contribute to the creation of a strong addictiogenic environment.

Furthermore, General Comment 14 notes that the right to health can be violated by 'the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others',[209] the failure to 'protect consumers … from practices detrimental to health',[210] and 'the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances'.[211] Several factors of the addictiogenic environment concern the actions of corporations, particularly their marketing and lobbying efforts,[212] and how these actions encourage the development of pseudo-relationships and facilitate vocational

[204] Article 12(2)(b), ICESCR.
[205] General Comment 14 n 196 above, para 15.
[206] ibid, para 4.
[207] ibid, para 32.
[208] For an example of this second point, see: C Cooper, 'Government 'buried' release of key evidence on minimum alcohol price before policy U-turn' (*independent.co.uk*, Wednesday 8 January 2014) available online at http://www.independent.co.uk/life-style/health-and-families/health-news/government-buried-release-of-key-evidence-on-minimum-alcohol-price-before-policy-u-turn-9045158.html (last accessed 9 June 2016).
[209] General Comment 14, n196 above, para 51.
[210] ibid, para 51.
[211] ibid, para 51.
[212] R Moodie et al, 'Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol and Ultra-Processed Food and Drink Industries' (2013) 381 The Lancet 670, 672.

consumption. Consequently, the control of these factors should also fall within the scope of the obligation to protect individuals from third party violations of the right to health.

The above analysis demonstrates that the absence of a strong addictiogenic environment should fall within the scope of the right to health, as interpreted by General Comment 14, and therefore that protection against the factors of the addictiogenic environment should be amongst the obligations that Article 12 ICESCR places on State parties. The next subsection will therefore investigate the nature of these obligations, as well as the question of whether the right to health places obligations on non-State actors.

iii. Obligations placed upon States and non-State actors by the right to health

Having established that Article 12 ICESCR (mirrored by Article 35 CFREU) should guarantee individuals a right to protection against strong addictiogenic environments, the obligations that this generates must now be considered.

Two principles enshrined within the ICESCR condition the general scope of any obligations that are placed on States by Article 12. States are only obliged to act 'with a view to achieving progressively the full realization of the rights'[213] included in the ICESCR. This means that States are not under an obligation to secure all the freedoms and entitlements conferred upon individuals by Article 12 on an absolute basis. Rather, States are obliged to 'move as expeditiously and effectively as possible'[214] towards the full realisation of Article 12.

States are also only obliged to fulfil their Article 12 obligations 'to the maximum of [their] available resources'.[215] General Comment 14 explains that the Covenant 'acknowledges the constraints due to the limits of available resources'[216] – clearly, States cannot spend huge sums of money in pursuit of every right conveyed by the ICESCR, and face difficult decisions over how to allocate their financial resources. However, States must nonetheless spend what they have available to them. General Comment 14 makes clear that if a State cannot spend more than a certain amount in pursuit of the right to health, they must show that 'every effort has nevertheless been made to use all available resources at its disposal'[217] and that a State violates its Article 12 obligation if it is 'unwilling to use

[213] ICESCR, Article 2(1).
[214] General Comment 14 n 196 above, para 31.
[215] ICESCR Article 2(1).
[216] General Comment 14 n 196 above, para 30.
[217] ibid, para 47.

the maximum of its available resources'.[218] Thus, Article 12 does not place absolute obligations upon States as a general rule, but rather an obligation to act as effectively as possible, and to allocate as much resource to such action as they can manage.

Within these limits, Article 12 places two types of legal obligation upon States – core legal obligations and specific legal obligations. Core legal obligations constitute exceptions to the two principles outlined above. They reflect the 'minimum essential levels'[219] of the rights conferred by Article 12, and they do place absolute obligations on States. A State 'cannot, under any circumstances whatsoever, justify its non-complicate with the core obligations'[220] of the right to health.

Specific legal obligations are broken down by General Comment 14 into three types – obligations to respect, protect and fulfil the right to health. Respecting the right to health places States under an obligation to refrain from any action that would generate negative health consequences for individuals.[221] Protecting the right to health places States under an obligation to take action to control risks to the health of individuals.[222] Finally, fulfilling the right to health places States under an obligation to ensure that their legal and political systems give sufficient recognition to the need to ensure that individuals are provided with conditions in which they can pursue their highest attainable level of health.[223]

Using the examples provided by General Comment 14, it is possible to identify several ways in which States should be obliged to protect individuals from the effects of the addictiogenic environment. First, as is becoming clear by now, States are certainly under an obligation to control irresponsible activities of corporations that manufacture and market potential objects of addiction, in particular irresponsible marketing. The need to control the marketing of potential objects of addiction is specifically mentioned in General Comment 14,[224] and as discussed previously, the evidence linking marketing to the increased appeal and consumption of addictive objects is considerable.[225]

[218] ibid, para 47.
[219] ibid, para 43.
[220] ibid, para 47.
[221] ibid, para 34.
[222] ibid, para 35.
[223] ibid, para 36.
[224] ibid, para 51.
[225] Weintraub et al, n 154 above; P Bindle, 'Exploring the Impact of Gambling Advertising: An Interview Study of Problem Gamblers' (2009) 7 International Journal of Mental Health Addiction 541.

Therefore, the existence of the right to health should oblige governments to control irresponsible marketing practices.

Second, it is clear from General Comment 14 that States should be under an obligation to ensure that policymaking processes are conducted in such a way as to avoid strengthening the addictiogenic environment. A violation of States' obligations will occur when there is a 'failure to take measures to reduce the inequitable distribution of health facilities, goods and services'.[226] Furthermore, States are under an obligation to 'undertake actions that create, maintain and restore the health of populations',[227] in addition to an obligation to fulfil rights 'when individuals or a group are unable, for reason beyond their control, to realise that right themselves'.[228] Taken together, it is arguable that this places an obligation on States to mainstream consideration of the addictiogenic environment into all relevant fields of policymaking. This obligation should lead States to rethink implications of certain policy choices, such as the arrangement of social welfare structures in ways that marginalise certain groups,[229] unwillingness to invest in the development of certain communities,[230] the promotion of liberal trade policies,[231] or policies that permit the dense availability of addictiogenic objects.[232]

These processes are beyond the ability of most individuals or groups to change, making it even more important that States take responsibility for ensuring that they do not contribute to the causation of addictions. Individuals, especially vulnerable individuals such as children, are not in a position to address the impact of the addictiogenic environment on their chances of avoiding addiction, making the guarantees in the right to health an important tool for ensuring that those who do have such power will control factors of the addictiogenic environment on behalf of vulnerable individuals.[233] Consequently, it is possible to conclude that Article 12 places an obligation upon States to ensure that the policies they pursue outside the health and social protection fields are arranged in such a way to to avoid strengthening the addictiogenic environment.

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[226] General Comment 14 n 196 above, para 52.
[227] ibid, para 37.
[228] ibid, para 37.
[229] L Greaves et al, 'The future of transdisciplinarity in addiction' in L Greaves et al (eds), *Transforming Addiction: Gender, Trauma, Transdisciplinarity* (New York: Routledge 2015) 218.
[230] Wilkinson and Marmot, n 136 above, 24.
[231] D Zeigler, 'International trade agreements challenge tobacco and alcohol control policies' (2006) 25(6) Drug and Alcohol Review 567.
[232] E Kuntsche et al, 'Alcohol outlet density, perceived availability and adolescent alcohol use: a multilevel structural equation model' (2008) 62 Journal of Epidemiology and Community Health 811.
[233] N Ezard, 'Public health, human rights and the harm reduction paradigm: from risk reduction to vulnerability reduction' (2001) 12 International Journal of Drug Policy 207.

A final example of obligations that Article 12 places on States in relation to the addictiogenic environment is an obligation to prevent the physical, social and cultural environment from becoming saturated with addictiogenic norms. In essence, States should not allow the environment in which their citizens live to become an environment in which addiction is celebrated, normalised or glorified in any way. Taking the observation in General Comment 14 that States should refrain from 'preventing people's participation in health related matters'[234] together with the observation that 'violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from the legal obligations',[235] along with the nature of States' obligations to respect the right to health, it is arguable that States should refrain from any actions that directly contribute to producing an environment in which vocational consumption of addictive substances could take place. By way of example, accepting sponsorship for the Olympic Games from corporations that produce potential objects of addiction would constitute a violation of this obligation.[236] Organising and advertising state lotteries would constitute another.[237] Both are instances where the State might have refrained from contributing to the strengthening of the addictiogenic environment, but did not. States should therefore ensure that they themselves are not directly contributing to the strengthening of the addictiogenic environment.

Since only States are parties to the ICESCR, only States can have legal obligations placed directly upon them by Article 12. However, this does not mean that the existence of a right to health under international law will not generate the expectation that certain responsibilities should fall upon non-state actors, whose actions have a direct bearing upon the enjoyment of the right to health. General Comment 14 acknowledges that other actors can contribute to the realisation of the right to health, not only with a section dedicated to the Obligations of Actors other than State Parties,[238] but with references throughout the text. Of particular relevance to addiction policy are the references made to the responsibilities of private businesses, whose actions produce some of the major factors of the addictiogenic environment.

General Comment 14 clearly acknowledges that the activities of corporations can influence individuals' health, and places an obligation upon States to reduce the impact of this influence.

[234] General Comment 14 n 196 above, para 34.
[235] General Comment 14 n 196 above, para 49.
[236] A Garde and N Rigby, 'Going for Gold – Should Responsible Governments Raise the Bar on Sponsorship of the Olympic Games and other Sporting Events by Food and Beverage Companies?' (2012) 17 Communications Law 42.
[237] C Clotfelter and P Cook, *Selling Hope: State Lotteries in America* (Cambridge, MA: Harvard University Press 1989).
[238] General Comment 14, n 196 above, paras 63-65.

However, General Comment 14 also acknowledges at several other points that corporations should bear direct responsibilities to act consistently with the right to health. The General Comment states that 'all members of society … intergovernmental and non-governmental organizitations, civil society organizations, as well as the private business sector – had responsibilities regarding the realization of the right to health'.[239] It further states that the private business sector should be 'aware of, and consider the importance of, the right to health in pursuing their activities'.[240] The fact that States are under an obligation to 'provide an environment which facilitates the discharge of these responsibilities'[241] further emphasises that corporate activities should be motivate by a respect for the right to health.

It is therefore arguable that Article 12 provides a normative basis upon which States could impose legal obligations to act consistently with the right to health directly upon corporations. The imposition of ethical and potentially legal duties upon corporations who have a bearing upon the enjoyment of the human rights, including the right to health, has been encouraged in documents such as the Norms on the Responsibilities of Transnational Corporations[242] and the Guiding Principles on Business and Human Rights.[243] The Norms state that 'transnational corporations… have, inter alia, human rights obligations and responsibilities and … these human rights norms will contribute to the making and development of international law'.[244] The drafters of the Norms even went as far as to voice their hope that through processes of interpretation and re-application, the Norms would 'amount to more than aspirational statements of desired conduct'.[245] Furthermore, the Guiding Principles set out that 'the responsibility to respect human rights is a global standard to expected conduct for all business enterprises',[246] that 'the responsibilities of business enterprises to respect human rights refers to internationally recognised human rights',[247] and that 'in practice,

[239] ibid, para 56.
[240] ibid, para 55.
[241] ibid, para 42.
[242] *Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights* (UN Sub-Commission on the Promotion and Protection of Human Rights, Economic, Social and Cultural Rights, 26 August 2003) E/CN.4/Sub.2/2003/12/Rev.2.
[243] J Ruggie, *Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework* (United Nations Office of the High Commissioner for Human Rights 2011).
[244] *Preamble to the Norms on the Responsibilities of Transnational Corporations*, n 242 above.
[245] D Weissbrodt and M Kruger, 'Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights' (2003) 97(4) The American Journal of International Law 901, 913.
[246] Ruggie, n 243 above.
[247] ibid.

some human rights may be at greater risk than others in particular industries or contexts, and therefore will be the focus of heightened attention'.[248]

The existence of these internationally proclaimed expectations that corporations will act compatibly with human rights norms provides further evidence that corporations that produce and market potential objects of addiction should be responsible for acting in ways that will not contribute to strong addictiogenic environments. Of course, for industries whose very existence arguably contributes to a strong addictiogenic environment, such as the tobacco industry, fulfilling these responsibilities will be difficult – the inherent conflicts of interest in what they would be asked to do are often too great to overcome.[249]

Consequently, this gives all the more reason for States to establish such responsibilities in law. In some States this has already been attempted. Argentina has included a horizontality provision in its Constitution that gives the ICESCR the same legal status as the Constitution,[250] thus providing Argentine citizens with the possibility of invoking the right to health as found in the ICESCR against a private party, such as a corporation. The Irish constitution has also been interpreted to be horizontally directly effective where such a construction is possible,[251] and contains a provision that requires the State to protect the public against unjust exploitation,[252] which could plausibly be invoked in a horizontal action between a citizen and a corporation. Although no examples have yet surfaced of such constitutional provisions being used against corporations, the possibility nonetheless remains for States to constitutionalise a right to health in order to provide direct legal recourse for citizens against corporations who have violated their right to health.

iv. Summary

To summarise the above discussion, the right to health contained in Article 12 ICESCR and echoed by Article 35 CFREU obliges Member States and the EU to work towards ensuring that all individuals can benefit from conditions that will allow them to pursue their highest level of health, and this includes the absence of a strong addictiogenic environment. States hold legal obligations (and non-state

[248] ibid.
[249] The effects of this conflict are explored in, for example: D Barnes and L Bero, 'Industry-funded research and conflict of interest: an analysis of research sponsored by the tobacco industry through the Centre for Indoor Air Research' (1996) 21(3) Journal Health Politics, Policy and Law 515.
[250] Constitution of Argentina (1994), Article 75.22, text available at http://www.parliament.am/library/sahmanadrutyunner/argentina.pdf (last accessed 22 September 2016).
[251] *Murtagh Properties Ltd. v Cleary* [1972] IR 330.
[252] Constitution of Ireland (1937), Article 45(3)(2), text available at http://www.taoiseach.gov.ie/eng/Historical_Information/The_Constitution/February_2015_-_Constitution_of_Ireland_.pdf (last accessed 22 September 2016).

actors hold responsibilities that could be turned into legal obligations) to ensure that environmental conditions will not promote, encourage or facilitate the development of addictions. These obligations provide a compelling rights-based justification for government legal intervention to control the factors of the addictiogenic environment. Having explored a rights-based justification, the second half of this chapter will examine how ethical principles might be balanced in order to justify legal intervention to control the factors of the addictiogenic environment.

IV. Ethical justification

A. Introduction

As highlighted above, law is a coercive tool that can potentially be used to override individual preferences, and even individual freedoms, in pursuit of policy goals. This is particularly the case when it comes to controlling strong addictiogenic environments, since some of the policies that are most evidentially effective rely on abridging the freedoms of corporations, on foreclosing certain lifestyle choices from individuals, on influencing the expected behaviour of individuals in certain situations, or even on changing societal norms.

These actions cannot be justified solely by reference to the existence of the right to health, since the actions, behaviour and norms abridged are often themselves protected by other fundamental rights. For example, corporate advertising is protected by the freedom of expression.[253] Consequently, a means of explaining why the balance between conflicting rights should be struck in favour of protecting the right to health is needed. This means can be provided by the application of ethical principles of public health. Such principles can provide justification for the adoption of addiction interventions despite the fact that conflicting freedoms have been abridged in the process. Since there are a number of ethical principles that could be applied to the use of law for public health purposes, not all of which are supportive, the first subsection below will first consider ethical principles that do not support the use of law in addiction policy. The subsequent subsections will then consider the ethical arguments that do support intervention on the addictiogenic environment. Ultimately, it will be argued that the need to protect populations against the effects of the addictiogenic environment outweighs the need to preserve an individual's supposed prerogative to choose to harm themselves.

[253] European Convention for the Protection of Human Rights and Fundamental Freedoms (published 4 November 1950, entry into force 3 September 1953) ETS 5, Article 10; Charter of Fundamental Rights of the European Union [2012] OJ C 326/02, 26.10.2012, 391, Article 11.

B. Arguments from the principle of autonomy

The principle of autonomy can be used to support a number of ethical arguments against lifestyle risk regulation in general, and could be raised in particular to support arguments that legal intervention is an inappropriate tool with which to combat addiction. The autonomy principle was originally applied in the medical and bioethical fields,[254] and was developed out of a concern to ensure that the individual retained ultimate control over their body. However, it has become recognised that autonomy can be a useful principle in the field of public health as well. Autonomy in the context of public health is concerned more with decision making relating to an individual's lifestyle.[255] Autonomy in this context could be understood as the freedom to discern and consider lifestyle options, and the freedom to act on the resulting evaluations in a voluntary way.[256] Understood in this way, the principle of autonomy has been used to support the following ethical arguments against legal intervention on addiction issues.

i. Anti-paternalism

First is the argument that individuals are always the best judge of their own interests, and that policymakers have no way of knowing what would increase an individual's well-being overall. This is a rejection of paternalism, a term which has traditionally indicated 'interference with the liberty of another for the purposes of promoting some good or preventing some harm'[257], but can which be more accurately understood as the exercise of government power over individuals to substitute the preferences of the individual for the preferences of governments. If an individual makes an autonomous decision that engaging with an object of addiction would increase their overall well-being, policy makers are neither able nor entitled to override that judgement on the basis that they believe it is not in that individual's best interests. Consequently, respect for individual autonomy means that policymakers should refrain from substituting their own lifestyle judgements for those of the individual in these situations, without more concrete overriding justification.[258]

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[254] D Callahan and B Jennings, 'Ethics and public health: forging a strong relationship' (2002) 92(2) American Journal of Public Health 169, 169.

[255] S Yoder, 'Individual responsibility for health: decision not discovery' (2002) 32(2) Hastings Center Report 22; T Pope, 'Balancing public health against individual liberty: the ethics of smoking regulations' (2000) University of Pittsburgh Law Review 419.

[256] W van Boom and A Ogus, 'Introducing, defining and balancing autonomy v paternalism' (2010) 3(1) Erasmus Law Review 1, 1; D Hausman and B Welch, 'Debate: To nudge or not to nudge' (2010) 18(1) Journal of Political Philosophy 123, 128; S Ben-Porath, *Tough Choices: Structured Paternalism and the Landscape of Choice* (Princeton University Press 2010), 6.

[257] M Merry, 'Paternalism, Obesity, and Tolerable Levels of Risk', (2012) 20(1) Democracy and Education 1, 2.

[258] K Grill, 'Paternalism' in R Chadwick (ed), *Encyclopedia of Applied Ethics,* 2nd edition (London: Elsevier 2012); Gostin, n 169 above, 3118.

This anti-paternalism argument relies upon the proposition that choices which result in harm to the individual cannot automatically be assumed to be irrational, and thus may not be overridden on a presumption that they were irrational.[259] Choices which may be objectively negative for health may be subjectively good for well-being. A rational choice is simply a process in which benefits and detriments are weighed, and a decision is made that is consistent with that weighing and which maximises well-being.[260] Therefore, it is logical that healthy or unhealthy decisions could be rational in different scenarios. Consequently, as White argues, 'since public health policy makers have no way of knowing what a "better" choice means for each individual, they have no basis on which to judge that [the] choice was irrational or to know what I would have chosen if I had chosen "irrationally"'.[261]

This argument has logical force, however the logic only holds if it is assumed that individuals are always able to conduct the weighing of benefits and detriments free from external influence. In situations that concern engagement with addictive objects, an individual could be considered to lack meaningful autonomy in two ways – if the individual's decision making capacity is reduced in some way by the addictiogenic environment, or if the decision making situation is unfairly manipulated by the addictiogenic environment.

An individual's decision making capacity can be reduced when, for example, an individual is already in an addictive relationship, or is highly vulnerable to developing an addiction. Evidence shows that those in particularly vulnerable or already addicted situations are far more likely to possess reduced levels of capacity to decide against consumption. For example, individuals addicted to tobacco can suffer from the 'loss of intellectual abilities'[262] as a result of tobacco related illnesses, and college students can be particularly susceptible to developing internet addictions due to heightened developmental vulnerabilities combined with the expectation to use something that is in plentiful supply.[263] This is not the full autonomy on which most ethical arguments against addiction intervention are based. When individuals are placed in a vulnerable position through addiction or the imminent development of an addiction, they feel that they have less choice, and less capacity to

[259] D Buchannan, 'Autonomy, Paternalism and Justice: Ethical Priorities in Public Health' (2008) 98(1) American Journal of Public Health 15, 17.
[260] See: A Tversky and D Kahneman, 'The Framing of Decisions and the Psychology of Choice' (1981) 211(4481) Science 453.
[261] M White, *The Manipulation of Choice: Ethics and Libertarian Paternalism* (New York: Palgrave MacMillan 2013), x.
[262] N Wilson and G Tomson, 'Tobacco taxation and public health: ethical problems, policy responses (2005) 61 Social Sciences and Medicine 649, 653.
[263] J Kandell, 'Internet addiction on campus: The vulnerability of college students' (1998) 1(1) Cyber Psychology and Behaviour 11.

choose than they might have had if they were placed in a less vulnerable situation.[264] By simply placing vulnerable individuals in a less vulnerable position, decision making processes may be different. In such situations, interventions to control the factors of the addictiogenic environment may actually increase an individual's autonomy, rather than abridge it.[265]

An individual's decision making situation can be unfairly manipulated when crucial pieces of information are withheld from individuals, or when attempts are made to influence the likely outcome of decision making in a particular direction. As Gostin notes, 'people face constraints (both internal and external) on the capacity to pursue their own interests … personal behaviour is heavily influenced and not simply a matter of free will'.[266] Such constraints might include marketing efforts that co-opt and exploit the behavioural decision-making biases of consumers in order to push them towards certain consumption decisions,[267] or the withholding or covering-up of scientific information relating to health harms in an attempt to undermine consumers' abilities to fully understand the implications of consumption decisions.[268] In such situations, the process of weighing benefits and detriments is not wholly, or sometimes even partly, the individual's own. Consequently, legal intervention that controls the factors of the addictiogenic environment in order to prevent these factors from manipulating individual choices would tend to increase the autonomy of individuals, rather than decrease it.[269]

ii. The harm principle

The second argument from the principle of autonomy against the use of law to control the addictiogenic environment is that due to the assumed intrinsic value of protecting and respecting a person's autonomy,[270] it is only ever permissible to restrict an individual's autonomous choice to engage with addictive objects if their behaviour would cause harm to others. When an individual only harms themselves through their engagement with an addictive object, the intrinsic value of

[264] G Williams et al, 'Testing a self-determination theory intervention for motivating tobacco cessation" Supporting autonomy and competence in a clinical trial' (2006) 25(1) Health Psychology 91.
[265] Wilson and Tomson, n 262 above, 653.
[266] L Gostin and K Gostin, 'A broader liberty: JS Mill, paternalism and the public's health' (2009) 123 Public Health 214, 216.
[267] J Hansen and Kysar, 'Taking behvaioralism seriously, the problem of market manipulation' (1999)74 New York University Law Review 630; NC Smith et al, 'Choice without awareness: Ethical and policy implications of defaults' (2013) 32(2) Journal of Public Policy and Marketing 159.
[268] J Hoek, 'Informed choice and the nanny state: learning from the tobacco industry' (2015) 129(8) Public Health 1038.
[269] See the arguments put forward in T Nys, 'Paternalism in public health care' (2008) 1(1) Public Health Ethics 64.
[270] Gostin and Gostin, n 266 above, 215.

preserving autonomy trumps the value of protecting their well-being,[271] even if an addiction is developed.

While the previous argument from autonomy was based upon the assumption that a rational decision may be objectively bad but still subjectively good for the individual, this argument from autonomy rests upon the proposition that even if a choice is subjectively bad for the individual, that choice is the individual's alone to make. To override autonomous choice in this situation would be an offence to the idea that individuals should be free to decide how their lives should be spent.[272] To declare that an individual is only entitled to make choices that increase their individual well-being constitutes a 'denial of self-determination'.[273] It is only if individual action affects the self-determination of others that public authorities should exercise power to limit that individual's freedom.[274] Thus, this argument from autonomy is essentially that individuals should be at liberty to act upon whatever their lifestyle convictions happen to be, no matter how distasteful they may seem to others, as such action does not compromise the freedom of others.[275]

However, the harm principle rests upon the assumption that decisions relating to the use of potential objects of addiction can be clearly separated into those that harm only the individual and those that harm others. In fact, the boundary between so called self-regarding and other-regarding behaviours is hard to define. When an individual develops an addiction, the immediately observable harm – liver cirrhosis due to vocational alcohol consumption for example, or bankruptcy from vocational gambling – might well be confined to the individual, however there are several other proximate harms that are often not as easily visible. For example, friends and family are often put through emotional trauma as a result of an individual's addiction, can be forced to pick up financial shortfalls suffered as a result of the addiction, or may have to look after offspring or spouses neglected by the addicted individual.[276] Those suffering from non-communicable disease as a result of their engagement with objects of addiction impose costs on national health services.[277] Addicted

[271] JS Mill, 'On Liberty' in B Wishy (ed), *Prefaces to Liberty: Selected Writings* (University Press of America 1959).
[272] J Feinberg, 'Legal Paternalism' (1971) 1(1) Canadian Journal of Philosophy 105, 115.
[273] S Holm, 'Obesity Interventions and Ethics (2007) 8(Suppl. 1) Obesity Reviews 207, 207.
[274] Mill, n 271 above.
[275] Feinberg, n 272 above, 115.
[276] J Orford et al, 'Family members affected by a close relative's addiction: the stress-strain-coping-support model' (2010) 17 (Suppl. 1) Drugs: Education, Prevention and Policy 36.
[277] R Sturm, 'The Effects of Obesity, Smoking, and Drinking on Medical Problems and Costs' (2002) 21(2) Health Affairs 245.

individuals can also place burdens on employers through reduced productivity.[278] Thus, it is quite hard to say that a choice in relation to potential objects of addiction will not have, or will not lead to, harms being suffered by others.

Any legal intervention to control the addictiogenic environment should therefore be considered a population health exercise.[279] An intervention that happens to restrict the autonomy of individuals who voluntarily choose to harm themselves is the same intervention that seeks to return autonomy to other individuals who would make non-harmful choices in the absence of a strong addictiogenic environment. Thus, the effect of a population level intervention upon some individuals within the population cannot easily be decoupled from its effects upon others within the population.[280] As Martin points out, the legitimacy of public health intervention 'focuses on the question of proportionality … only in circumstances where the individual can establish significant burden over and above that borne by members of the majority population will there be any grounds for challenge'.[281] This being the case, the legitimacy of legal intervention to control factors of the addictiogenic environment comes down to the balancing of one group's right to self-determination against another group's right to the same thing. At this point, an argument based on the harm principle would appear to break down, since an assertion founded on the repugnancy of restricting autonomy cannot surely be used to support action that would itself restrict autonomy.

In summary, arguments from autonomy could be used to oppose the use of law in addiction policy. These arguments rely upon the presumption of both the absolute infallibility of and absolute superiority of an individual's ability to self-determine. However, as has been suggested above, autonomous choice is not an absolute reality, since the addictiogenic environment is sometimes strong enough to alter an individual's decision making in such a way that their choices are not truly autonomous. Furthermore, even if individual autonomy were absolute, the fact that public health policymaking must balance the health interests of the whole population, and arrive at an outcome that benefits the *population* as a whole, means that the preservation of the autonomy of some cannot be used to justify the erosion of the autonomy of others. Having explored the main ethical arguments against the use of law in addiction policy, we turn now to explore the ethical arguments that support it.

[278] K Young, 'Internet Addiction: A New Clinical Phenomenon and its Consequences' (2004) 48(4) American Behavioural Scientist 402.
[279] Gostin and Gostin, n 266 above, 217.
[280] D Beauchamp, 'Community: the neglected tradition of public health' in D Beauchamp and B Steinbock (eds), *New Ethics for the Public's Health* (Oxford University Press 1999), 57.
[281] Martin, n 174 above, 852.

C. Arguments from the principle of social justice.

The idea that society should be organised in a socially just manner flows from a number of distinct ethical values – fairness,[282] equality,[283] solidarity,[284] and protection of the vulnerable.[285] Taken together, these ethical building blocks can be understood to constitute an idea that 'each person in society ought to receive his due and that the burdens and benefits of society should be fairly and equitably distributed'.[286] From a public health perspective we could narrow this principle down to the idea that policymakers should be required to 'advance human well-being by improving health and to do so by focussing on the needs of the most disadvantaged'.[287] Specifically, an approach to public health practice that reflects the principle of social justice would focus on correcting 'patterns of systematic disadvantage that undermine the well-being of people',[288] especially when some groups of people 'whose prospects for well-being, including for health, are so limited that their life choices are not even remotely like those of others'.[289] Understood in this way, it is arguable control of the factors of the addictiogenic environment should be the business of any society that aspires to be organised in socially just manner. There are two main reasons for this.

First, in a socially just society that is nevertheless also founded on liberal values, powerful members of the society should not be permitted to exploit the hardships experienced by weaker and more vulnerable members of the society. Deliberately seeking to make profit of the expense of the health and well-being of those vulnerable members is a practice that certainly does not result in an equitable distribution of benefits and burdens, and is therefore to be discouraged.

It is evident that free market conditions will always favour those with greater resources and power.[290] This is particularly true for markets in addictive goods – multinational corporations are by far the largest producers and marketers of many potential objects of addiction such as tobacco,

[282] J Rawls, 'Justice as fairness' (1958) 67(2) The Philosophical Review 164.
[283] E Anderson, 'What is the point of equality?' (1999) 109(2) Ethics 287.
[284] F Baylis et al, 'A relational account of public health ethics' (2008) 1(3) Public Health Ethics 196.
[285] M Fineman, 'The vulnerable subject: anchoring equality in the human condition' (2008) 20(1) Yale Journal of Law and Feminism 1.
[286] D Beauchamp, 'Public health as social justice' (1976) 13(1) Inquiry 3, 3.
[287] L Gostin and M Powers, 'What does social justice require for the public's health? Public health ethics and policy imperatives' (2006) 25(4) Health Affairs 1053, 1054.
[288] ibid.
[289] M Powers and R Faden, *Social Justice: the moral and foundations of public health and health policy* (Oxford University Press 2006), 81.
[290] Gostin and Powers, n 287 above, 1058.

alcohol and gambling services,[291] and dominate the globalised marketplace. For example, just 10 multinational corporations are responsible for nearly half of all global sales of branded alcoholic beverages.[292] Such corporations therefore possess an immense amount of economic leverage, particularly over the consumers that are buying their products. Given that the objective of multinational corporations is to accumulate as big a market share as possible and will therefore look to secure a market advantage wherever possible, and given that consumers are reliably subject to a variety of cognitive flaws and vulnerabilities, multinational corporations take advantage of these decision making vulnerabilities in order to manipulate consumer choice and behaviour towards greater consumption.[293] This is not least because the legal structure of corporations places its directors under a fiduciary duty to maximise profits on behalf of the company's shareholders, even if this comes at the expense of public goods such as health.[294] Thus, powerful and resourceful corporations that sell potential objects of addiction grow economically stronger, while the very customers who are being manipulated in order to feed this growth suffer ever greater health detriments.[295]

In such situations, the position of individuals who are particularly vulnerable to developing addictive relationships is compounded - not only do corporations control the products and services to which individuals might turn for an addictive relationship, but they also actively attempt to make these products more appealing through marketing and branding activities, in an effort to encourage greater consumption.[296] There is nothing fair or equitable or just in allowing multinational corporations with such power to profit at the expense of vulnerable individuals or communities.[297] A society that aspires to be socially just should not allow the powerful to reap greater benefits by compounding the burdens of the already vulnerable.[298] The pursuit of social justice would therefore support action that sought to even the balance of power between corporate actors and vulnerable individuals, by controlling factors of the addictiogenic environment that are related to the activities of addiction industries and other economic actors.

[291] N Freudenberg, *Lethal But Legal: Corporations, Consumption, and Protecting Public Health* (Oxford University Press 2014).
[292] D Jernigan, 'The global alcohol industry: an overview' (2009) 104(s1) Addiction 6, 7.
[293] See the analysis presented in: Hansen and Kysar, n 267 above.
[294] A Gilmore et al, 'Public health, corporations and the New Responsibility Deal: promoting partnerships with vectors of disease? (2011) 33(1) Journal of Public Health 2, 2.
[295] M Brezis et al, 'Vulnerability to health and market forces' (2011) 49(3) Medical Care 232.
[296] Hastings, n 119 above.
[297] See the arguments presented in: M Monshipouri et al, 'Multinational corporations and the ethics of global responsibility: problems and possibilities' (2003) 25 Human Rights Quarterly 965.
[298] W Wiist, 'Public health and the anti corporate movement: Rationale and recommendations' (2006) 96(8) American Journal of Public Health 1370.

Second, the fact that preventable social inequality exacerbates the vulnerability of individuals to the influence of the addictiogenic environment should be seen as cause for a society that aspires to be socially just to intervene in order to reduce inequality and weaken the links between inequality and addiction development.

There is a clear link between social inequality and the prevalence of addiction. For example, the negative consequences of licit and illicit drug use have been found to fall disproportionately upon poorer members of society.[299] Social exclusion, social upheaval and socioeconomic deprivation all increase the chances that individuals will develop an addiction in response to the high levels of negative affect that such conditions generate.[300] Stigmatisation of the use of potential objects of addiction, particularly by lower socioeconomic groups, exacerbates the negative affect generated by being socially disadvantaged in the first place, and consequently the harms arising from the use of potential objects of addiction.[301] Finally, the experience of deprivation in childhood can be linked to higher risk of addictive behaviour in adulthood.[302] Of course, the link between inequality and addiction does not take away from the fact that individuals from advantaged backgrounds can also suffer social dislocation. One however cannot ignore the fact that more disadvantaged individuals are far more likely to be put in positions where they risk becoming socially dislocated. Inequality, although not the only driver of addiction development, should therefore be considered a reason in itself to take action on the addictiogenic environment.

Being poorer, less advantaged, less socially included and in general less well-off is linked to higher rates of addiction because individuals in such situations are more likely to be vulnerable to the influence of the three core groups of factors of the addictiogenic environment. Disadvantaged individuals are more likely to experience conditions that generate social dislocation.[303] Not only is social dislocation more likely in the less well-off, the provision and promotion of potential objects of addiction exploits the less well off-to a greater extent. Studies have consistently found that deprived neighbourhoods are more likely to have greater densities of unhealthy food, tobacco and gambling

[299] M Singer, *Drugging the Poor: Legal and Illegal Drugs and Social Inequality* (Long Grove, IL: Waveland Press 2008), 3.
[300] M Stead et al, '"It's as if you're locked in": qualitative explanations for area effects on smoking in disadvantaged communities' (2001) 7(4) Health and Place 333; Wilkinson and Marmot, n 136 above, 24-25.
[301] Room, n 125 above.
[302] R Poulton et al, 'Association between children's experience of socioeconomic disadvantage and adult health: a life course study' (2002) 360(9346) Lancet 1640.
[303] For examples of the literature, see: Wilkinson, n 86 above, 177; A Bhalla and F Lapeyre, *Poverty and Exclusion in a Global World*, 2nd Ed, (Basingstoke: Palgrave Macmillan 2004), 12; H Klein, 'Health inequality, social exclusion and neighbourhood renewal: Can place-based renewal improve the health of disadvantaged communities?' (2004) 10(3) Australian Journal of Primary Health 110.

outlets,[304] meaning that it is easier for less well-off individuals, already exposed to greater sources of negative affect, to access potential objects of addiction. The way in which addictive objects are often advertised through linking consumption to aspirational ideas and emotions means that it is more likely that individuals in disadvantaged or otherwise vulnerable positions will be enticed to engage in greater consumption of such objects.[305]

The relationship between preventable inequality and the operation of the addictiogenic environment is sufficiently strong to warrant intervention in the name of social justice. In the words of Sunstein, 'a society in which people "prefer" to become drug addicts … has a serious problem'.[306] For this reason, a society that seeks to uphold the principles of social justice would be justified in seeking to control the factors of the addictiogenic environment through legal intervention.

D. Arguments from the principle of stewardship

The second ethical argument that could be raised in favour of controlling the factors of the addictiogenic environment through legal intervention is founded upon the stewardship principle. The idea that mankind are stewards of the natural resources of the planet was first developed in religious texts,[307] however over time the concept of stewardship was adopted in a political context, and extended to include the idea that mankind collectively has a responsibility for looking after itself as well as its resources. In such a context, stewardship could be understood as the proposition that 'liberal states have responsibilities to look after important needs of people both individually and collectively'.[308] With respect to the health needs of populations, this responsibility translates into an ethical 'obligation upon States to seek to provide conditions that allow people to be healthy'.[309] Further definitions of the idea of government stewardship focus upon agency – 'willingness and ability to earn public trust by being an ethical agent in carrying out the republic's business'[310] – and

[304] S Schneider and J Gruber, 'Neighbourhood deprivation and outlet density for tobacco, alcohol and fast food: first hints of obesogenic and addictive environments in Germany' (2012) 16(7) Public Health Nutrition 1168; Wardle et al, n 18 above.
[305] See for example: R Bansal et al, 'Cigarette advertising in Mumbai, India: targeting different socioeconomic groups, women, and youth' (2005) 14 Tobacco Control 201.
[306] C Sunstein, *Free markets and social justice* (Oxford University Press 1999), 5
[307] R Saltman and O Ferrroussier-Davies, 'The concept of stewardship in health policies (2000) 78(6) Bulletin of the World Health Organization 732, 732.
[308] Nuffield Council on Bioethics, *Public Health: Ethical issues* (London: Nuffield Council on Bioethics 2007), 25.
[309] ibid.
[310] H Kass, 'Stewardship as a fundamental element in images of public administration' in H Kass and B Catron (eds), *Images and identities in public administration* (London: Sage 1990), 113.

accountability – 'willingness to be accountable for the well being of the larger organisation by operating in service, rather than in control of those around us'.[311]

The principle that governments and other public authorities are stewards of the public good therefore requires them to act on behalf of their citizens to ensure that their health is protected, rather than put at risk. Based on this principle, it is possible to argue that governments should ensure that their citizens are not exposed to conditions that promote, encourage and facilitate the development of addictions. There are two building blocks to this proposition. First, individuals delegate power to a governing authority because they are unable to secure certain public goods themselves. Second, individuals delegate power to the governing authority to act on behalf of the community under a social contract, on the expectation that this power will actually be exercised to secure the public goods that could not be achieved through individual action.

The election of a government is an acceptance of the fact that some 'public goods' cannot be secured by private individuals or groups.[312] Health is just such a public good,[313] being a basic requirement that is necessary for human functioning and the enjoyment of most freedoms.[314] As Gostin notes, 'acting alone, individuals cannot ensure even minimum levels of health … no single individual, or group of individuals, can ensure the health of the community'.[315] Recognition that community action through a duly appointed authority that will act on behalf of the community is therefore essential if the community is to prosper. Citizens consequently 'willingly forego the liberty of the hypothetical state of nature in favour of civil society where they can achieve, in the words of John Locke, "mutual Preservation of their Lives, Liberties and Estates"'.[316]

In electing a government for the purpose of 'mutual preservation', a so-called 'social contract' is formed. The social contract might be broadly thought of as 'the collective will of a community … to live together in an enduring nation state',[317] and as Hodge and Eber note, a 'government's responsibility to safeguard the public's health through law has been part of the social contract since

[311] P Block, *Stewardship: choosing service over self interest* (San Fancisco: Berret Koehler 1993), xx.
[312] Gostin, n 141 above, 2838.
[313] L Chen et al, 'Health as a global public good' in I Kaul et al (eds), *Global Public GoodsL International Cooperation in the 21st Century* (OUP 1999), 285.
[314] See Leary, n 195 above, 36.
[315] Gostin, n 141 above, 2838.
[316] W Parmet, *Populations, public health and the law* (Washington DC: Georgetown University Press, 2009), 14-15.
[317] K Calman, 'Beyond the "nanny state": Stewardship and public health' (2009) 123 Public Health e6, e7.

ancient times'.[318] Therefore, the existence of the social contract is designed to ensure that the power, trust and responsibility delegated to a government is used only in service to and on behalf of the population. Governments acting in accordance with the social contract should therefore 'typically favour measures to promote the welfare of citizens'.[319] As Kass explains, if a society's government can be thought of as the agent of the society's needs, then the social contract is an undertaking that the government 'must substitute its capacities for those lacking in the [population] so that the welfare of the [population] is achieved'.[320] A government that is delegated power for the purpose of securing public goods on behalf of a population is under an obligation to actually use those powers in order to actually secure those public goods.

Control over the factors of the addictiogenic environment is an excellent example of a public good that is beyond the ability of individuals to achieve, and which should be subject to the social contract arising from the delegation of power to governments and other public authorities.[321] As Alexander has argued, the strength of an addictiogenic environment depends on the level of control that the free-market is subject to.[322] Private individuals or groups are powerless to change the direction of market forces, however governments do possess such power – power to regulate markets, shape social structures, prohibit undesirable conduct and reward desirable conduct – which is delegated to them as part of the social contract between individuals and their government. Alexander argues that 'concerted social action can domesticate today's globalising free-market society, bringing dislocation [and consequently the addictiogenic environment] to heel',[323] and that this is possible because, collectively, we are 'human beings whose qualities of reason, compassion, and courage come to the fore in times of crisis'.[324]

If addictiogenic environments can therefore be controlled by public action for the good of the community, the principle of stewardship, which obliges governments to secure conditions for pursuing good health on behalf of citizens, would certainly justify the application of law in order to control the factors of the addictiogenic environment.

[318] J Hodge and G Eber, 'Tobacco Control Legislation: Tools for public health improvement' (2004) 32(3) The Journal of Law, Medicine and Ethics 516, 516.
[319] Calman, n 317 above, e7.
[320] Kass, n 310 above, 116.
[321] Chen et al, n 313 above, 289.
[322] B Alexander, n 75 above .
[323] ibid, 363.
[324] ibid, 363.

E. Balancing the ethical arguments

The analysis above explored ethical arguments that both support and oppose the use of legal intervention in order to control the factors of the addictiogenic environment. As with all complex policy problems that have an ethical dimension, fully reconciling the conflicts between ethical positions is very difficult.[325] Therefore, a position must be reached that achieves a balance between the relevant ethical principles.[326] Kass argues that a framework for analysing the ethics of public health should be adopted in order to guide such a balancing exercise.[327] Her proposed framework involves consideration of six elements of the public health intervention in question – the goals and effectiveness of the proposed intervention, the potential burdens of the intervention and whether they can be minimised, and whether the implementation of the intervention and the balancing of its burdens and benefits is fair.[328] Kass argues that 'weighing alternatives according to this public health ethics framework should lead to an ethically acceptable option'.[329] Applying the same approach to the ethical arguments for and against legal intervention in the addictiogenic environment therefore should reveal whether such intervention is justified.

On balance, one can argue that, while it is important to preserve individual autonomy as much as possible, the addictiogenic environment presents a serious threat to population health, to which legal intervention can make an unparalleled contribution to controlling. The evidence supporting many legal interventions is compelling – the goal of legal intervention is clearly to do good for the population, and the outcomes achieved by legal intervention often cannot be achieved through any other non-coercive means. Gostin and Gostin summarise the position as follows:

> 'If paternalistic measures reduce illness and premature death significantly with minimal burdens on individual freedom, should they be out of bounds simply because they fail to meet a philosophical standard of self-sovereignty? Should a caring society refuse to act when its members suffer such high burdens of preventable disease? If so, public health agencies would become powerless to respond effectively to the most common causes of disability and death; personal lifestyle choices'.[330]

[325] For an illustration, see the discussion in: M Roberts and M Reich, 'Ethical analysis in public health' (2002) 359 Lancet 1055.
[326] L Lee, 'Public health ethics theory: review and path to convergence' (2012) 40(1) Journal of Law, Medicine and Ethics 85, 86.
[327] N Kass, 'An ethics framework for public health' (2001) 91(11) American Journal of Public Health 1776.
[328] ibid, 1777-1781.
[329] ibid, 1782.
[330] Gostin and Gostin, n 266 above, 217.

To this it could be added that interventions that seek to address the balance of power between powerful corporations and vulnerable individuals are certainly fair. It is very difficult to deny the equity of the argument that 'many citizens are not benefited by growth, and at a minimum government should take steps to combat human deprivation and misery in the midst of growth'.[331] Furthermore, while individual experiences of addictive objects and addiction may subjectively harm or promote well-being depending upon their individual circumstances, thus either promoting or degrading individual autonomy, when addressing public health issues such as the addictiogenic environment, policymakers 'must take a broad view of the determinants and, indeed, the sustainability of population health'.[332] Thus, priority must be given in addiction policy to the needs of the population, rather than the needs of some individuals. Interventions that target the addictiogenic environment are designed to promote the health of populations above all else, and thus should be considered to balance the burdens of intervention in a way that maximises overall wellbeing.[333]

The consequences of a strong addictiogenic environment for the creation of a socially just society, in which public goods are defended, generates a clearer imperative for action than the imperative for inaction generated by the need to protect an individual's capacity to choose to harm themselves. In line with the idea that ethical principles should be applied as an overall framework, the ethical principles that would support intervention are more convincing. The arguments from individual autonomy – raised against the proposition that socially just societies should control factors of the addictiogenic environment to protect their populations – are flawed, and do not stand up to scrutiny. Since the population of a society delegates power to governments to ensure the continued survival of the society, it would seem proper to lend more weight to protecting the population as opposed to individuals' (uncertain) capacity for autonomy. Consequently, the application of a framework of ethical principles to the issue of addiction prevention would, it is argued, support legal intervention to control factors of the addictiogenic environment.

V. Conclusion

The purpose of this chapter was to set out the normative foundations upon which intervention to address the public health and social problems presented by the addictiogenic environment might be

[331] Sunstein, n 306 above, 6.
[332] A McMichael and R Beaglehole, 'The changing global context of public health' (2000) 356 Lancet 495, 495.
[333] On the idea that interventions in the public health field are aimed at promoting population health first and foremost, see: Gostin, n 141 above.

based, in order to regain control over the factors of the addictiogenic environment, reduce preventable addiction, and contribute to stepping up actions in the fight against NCDs. Two justifications for the use of law in controlling the factors of Europe's currently strong addictiogenic environment were put forward –a rights-based justification based on the right to health, and an ethics-based justification based on the principles of social justice and stewardship.

The right to health guarantees the provision of conditions in which individuals can live a life free of health-damaging addictions, and the Member States and the EU are under legal obligations to work expediently towards achieving such conditions, and avoid any actions which might put that objective in jeopardy. A socially just society will seek to eliminate inequalities wherever they exist, and pronounced inequalities exist in how individuals and communities are affected by the factors of the addictiogenic environment. Moreover, public authorities that have been delegated powers to provide public goods, such as the absence of a strong addictiogenic environment, should use those powers in order to re-shape the addictiogenic environment, acting on behalf of individuals who cannot achieve this themselves.

These normative cases for action provide strong justification for the use of legal interventions to control the factors of the addictiogenic environment. Objections may be made that law is a coercive force that has no business being applied in order to shape individual lifestyles. However, the first responsibility of governments is ultimately to protect their populations. Thus, as was demonstrated in this chapter, when individuals are being inequitably deprived of opportunities for achieving their highest level of health – opportunities that they not only expect their governing authorities to provide, but are entitled to receive – the well-being of populations must be prioritised above objections to government intervention in individual lifestyles.

Having established that public authorities would have a justified case for the use of law in combatting preventable addiction, the next chapter of this thesis seeks to make the case for the particular involvement of the EU in this endeavor. As outlined in the first chapter, the EU's Member States have made a commitment to stepping up actions in the fight against NCDs, an objective that they cannot achieve individually in the conditions of globalisation that currently shape and define how governments protect their populations. Fueled as it is by the relentless engine of global free market competition, the addiction phenomenon is an aspect of NCD development that especially cannot be tackled by individual countries acting alone. Supranational organisations such as the EU must contribute to controlling the factors of the addictiogenic environment, if preventable addiction

is to be successfully reduced in Europe. The next chapter therefore discusses in more detail the rationale for EU involvement in addiction policy, and the legal powers that would permit this involvement.

CHAPTER FOUR – DESIRABILITY OF AND COMPETENCE FOR EU INTERVENTION

I. Introduction

So far, this thesis has argued that the addiction phenomenon may be understood according to an addictiogenic environment model, whereby certain factors of an individual's environment will, if uncontrolled, promote, encourage and facilitate the development of addictions, together creating conditions in which individuals suffering hard times might consider adapting to a life of focused vocational consumption of an object of addiction, with which they establish a pseudo-relationship, in order to cope with the experience of social dislocation. It was then argued that, in order to control the factors that constitute the addictiogenic environment, the use of legal interventions could be normatively justified by the existence of right to health, social justice and stewardship obligations that are placed upon public authorities.

In this chapter, the contribution that EU policymakers should be expected to make to addiction policy in Europe will be analysed. Chapter One highlighted two points. First, some factors of the addictiogenic environment are generated by the fact that markets for potential objects of addiction are no longer confined by national borders. The trade in and promotion of products such as alcohol and tobacco, and services such as gambling, transcends nations. As such, a transnational response is often needed. Second, the EU has an obligation enshrined by the Treaties to assist the Member States in the development of their public health and social agendas. Article 168(1) states that 'The Union shall encourage cooperation between the Member States in the areas referred to in this

Article and, if necessary, lend support to their action' and Article 153(1) states that 'the Union shall support and complement the activities of the Member States in the following fields: … (j) the combatting of social exclusion; (k) the modernisation of social protection systems'. Since all Member States have committed internationally to stepping up action in the fight against NCDs, part of which should involve combatting the root causes of addiction, the EU should consequently be obliged to assist its Member States in constructing effective and evidence based addiction policies.

The EU, however, operates on the basis of conferred powers, which means that the EU cannot simply contribute to addiction governance in any way it wishes. It can only contribute using the powers that are conferred upon the EU legislature by the Member States.[334] Since the EU began as a project to create interdependencies in the economies of the Member States rather than a project that integrated economic and social concerns,[335] public health and social policy concerns were not initially part of the EU's mandate,[336] and thus the EU's powers in these fields are only just beginning to take real shape. The continuing bias towards achieving economic rather than social goals has meant that, despite the expansion of the EU's competences the fields of public health and social protection, there is still significant antipathy towards the involvement of the EU in sensitive aspects of these fields,[337] such as the control of the addictiogenic environment.

Therefore, one cannot simply assume that, because some factors of the addictiogenic environment require a transnational response, the EU will be able to provide this response. Although it is true that the objectives of the EU have become gradually more socially and health oriented,[338] the necessity of EU action in the addiction field will not be accepted as a given in most quarters. It must be shown that the EU should and could contribute to the control of the addictiogenic environment, in support of its Member States' efforts to step up action in the fight against NCDs.

The first half of this chapter will therefore analyse arguments for and against the granting of competences to the EU that would permit action on addiction, and will seek to develop a rationale for why the EU should use the powers it has been granted to contribute to the control of Europe's addictiogenic environment. The second half of this chapter will subsequently analyse the EU's

[334] Consolidated Version of the Treaty on European Union [2008] OJ C115/13, 9.5.2008, 47, Article 5(2).
[335] F Scharpf, 'The European Social Model: Coping with the Challenges of Diversity' (2002) 40(4) Journal of Common Market Studies 645, 646-647.
[336] M McKee et al, 'The influence of European Law on National Health Policy' (1996) 6(4) Journal of European Social Policy 263, 265; B v Maydell et al, *Enabling Social Europe* (Berlin: Springer 2006), 22.
[337] Scharpf, n 335 above, 646-647.
[338] M Jepsen and A Serrano Pascual, 'The European Social Model: an exercise in deconstruction' (2005) 15(3) Journal of European Social Policy 231.

competences to act in the fields of public health, social protection and the internal market, to show that the the EU has all the legal powers that it needs in order to discharge its addiction policy responsibilities.

II. Desirability of EU action on addiction issues

As highlighted above, the EU must show that it is competent to act in a certain policy field before acting. In fields where the EU shares competence with the Member States, or where it is only competent to lend support to the Member States, the question of the intensity of action that is permitted is complex. This is especially the case when it comes to the phenomenon of addiction. As the CJEU confirmed in its *Aragonesa* judgement, a case which dealt with the regulation of alcohol advertising, when no EU harmonisation exists in a certain field, 'it is for the Member States to decide on the degree of protection which they wish to afford to public health and on the way in which that protection is to be achieved'.[339] The Member States are therefore extremely keen to protect their right to deal with social and health issues that are not already covered by common European standards, such as the field of addiction policy, and have consequently opposed the extension and application of EU competences to such issues.

A. Arguments against EU action on addiction issues

Member States often wish to exclude EU action on sensitive public health and social questions, such as the prevention of addiction, because they are unwilling to allow external decision makers, perhaps with no foreknowledge of the social dynamics that exist within their national territory, to influence choices on how they safeguard the well-being of their own nationals.[340] One factor underlying this concern is that 'cultural meanings instilled in human beings standardize their choices'[341] – any effort to manage or guide individual choice, for instance on the consumption of potential objects of addiction, must take account of the cultural biases instilled in individuals by their cultural upbringing, which will be different from Member State to Member State. The Court of Justice of the European Union (CJEU) has highlighted this in its case law, for example recognising that the consumption of alcohol 'is linked to traditional social practices and to local habits and

[339] Joined Cases C-1/90 and C-176/90 *Aragonesa de Publicidad Exterior SA and Publivía SAE v Departamento de Sanidad y Seguridad Social de la Generalitat de Cataluña* [1991] ECLI:EU:C:1991:327, para 16.
[340] S Greer, 'Uninvited Europeanization: Neofunctionalism and the EU in Health Policy' (2006) 13(1) Journal of European Public Policy 134, 135.
[341] P Bohannan, *How Culture Works* (New York: The Free Press 1995), 9.

customs'.[342] Consequently, the argument can be made that those best placed to factor the influence of cultural bias into the re-shaping of the addictiogenic environment are national and subnational level decision makers, and that responsibility for addiction policy should therefore be kept at the national level. National governments should not have their ability to balance sensitive cultural, public health and social concerns compromised by interference from European policy makers who may have very limited knowledge of the way in which individuals brought up in different cultures will react to certain legal interventions. It is certainty true that public health interventions should be culturally sensitive in order to be most effective,[343] and given that dozens of different cultures exist within the European Union, the argument can be made that setting common standards of protection will have undesired effects in at least some Member States.

Another reason why Member States are reluctant to allow the EU to intervene to any great extent on public health or social issues is that they are wary of inviting what might be perceived as interference from an organisation that is perceived to lack institutional capacity to understand or act on social or public health concerns. As mentioned above, the EU has 'traditionally focussed on essentially economic tasks',[344] and its role in social and public health matters is seen as 'weak and circumscribed'[345] by the Member States. As Radaelli points out, EU policymaking is largely perceived as being technocratic – based on knowledge, rationalisation, and expert discussion.[346] Add two further perceptions to this – that 'the technocrat feels uneasy under conditions of political conflict, ideological debates, and controversies on distributive issues of social justice',[347] and that EU policymakers have 'limited expertise in the field of public health'[348] – and the result has been a deeply ingrained belief that EU policymakers are ill-equipped to effectively manage social and public health issues such as the addictiogenic environment. This belief is reinforced by the EU's 'absence of budgetary resources'[349] in public health and social policy. All in all, it is understandable that the nature of EU decision making should be targeted when making arguments that the EU should not play a major role in public health or social policymaking.

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[342] Case C-405/98 *Konsumentombudsmannen (KO) v Gourmet International Products AB* (GIP) [2001] ECLI:EU:C:2001:135, para 21.
[343] K Resnicow et al, 'Cultural sensitivity in public health: defined and demystified' (1999) 9(1) Ethnicity and Disease 10.
[344] Greer, n 340 above, 134.
[345] ibid.
[346] C Radaelli, 'The public policy of the European Union: whither politics of expertise?' (1999) 6(5) Journal of European Public Policy 757.
[347] ibid, 760.
[348] S Princen and M Rhinard, 'Crashing and Creeping: Agenda-setting Dynamics in the European Union' (2006) 13(7) Journal European Public Policy 1119, 1124.
[349] W Lamping and M Steffen, 'European Union and Health Policy: The "Chaordic" Dynamics of Integration' (2009) 90(5) Social Science Quarterly 1361, 1368.

Consequently, the Member States have been reluctant to hand over any measure of control to the EU that will allow EU intervention on the question of addiction. This is borne out by the high levels of opposition to EU involvement in policy fields related to addictive objects, opposition which often demonstrates that Member States reject EU involvement for more inward looking reasons. For example, during the revision of the Tobacco Products Directive, Poland voiced consistent opposition to the proposals – their reasoning was dominated by concerns that the Directive would have negative economic consequences for Poland on account of tax revenue lost from reduced tobacco sales, and by the fact that Poland is the largest manufacturer of flavoured cigarettes in the EU.[350] The House of Lords European Union Committee's report on a new EU Alcohol Strategy notes in its chapter on alcohol taxation that proposals to update EU alcohol tax directives dating from 1992 were blocked in the European Council in 2010 and not discussed since, and notes in particular the opposition of British MEPs to reviewing alcohol excise rates on account of the large revenues that the UK receives in taxation from alcohol sales.[351] EU harmonisation measures relating to online gambling and money laundering were also opposed by Maltese MEPs, unsurprising given Malta's permissive stance towards gambling regulation, and thus its high stake in gambling revenues.[352] Clearly then, Member States are reluctant for the EU to intervene in policymaking on addictive objects, especially when national interests are at stake. Having considered the arguments against EU legal intervention to help control the factors of the addictiogenic environment, the next section will move on to consider arguments that support such intervention.

B. Arguments for EU action on addiction issues

Despite the reluctance of the Member States to allow the EU to have any significant role in addiction policymaking, there are sound reasons why the EU should contribute to control of the addictiogenic environment. The first is that several important factors of the addictiogenic environment involve the movement of products and services across borders. As Beaglehole and Yach argue, 'the modern phase of globalisation' has resulted in 'the increasingly globalised production and marketing of

[350] See: M Zatonski, 'Evidence-based policymaking? The case of Polish opposition to the EU Tobacco Products Directive' (2016) 2(1) Journal of Health Inequalities 36, 38.
[351] House of Lords European Union Committee, *Eighth Report: A new EU Alcohol Strategy?* (2015) available online at http://www.publications.parliament.uk/pa/ld201415/ldselect/ldeucom/123/12302.htm, para 126.
[352] See V Pop, 'Gambling in the EU: A long way from harmonised rules' (*euobserver.com*, Berlin, 7 April 2014), available online at https://euobserver.com/economic/123649 (last accessed 22 September 2016).

tobacco, alcohol, and other products with adverse effects on health'.[353] When objects of addiction are produced by multinational corporations that operate on a global scale, it is inevitable that many activities of theirs that constitute factors of the addictiogenic environment, such as the marketing of products[354] or political lobbying,[355] are not constrained by national borders. The very fact that the vast majority of addictive objects are goods and services that circulate within the internal market means that activities conducted in relation to trade in these goods will have a cross border dimension.[356] Using the globalised marketplace, corporations act as 'vectors of disease',[357] that contribute to the addictiogenic environment without regard for national borders. The tactics that are used to subvert effective public health interventions[358] can be applied either to national political processes or to supranational political processes.[359] In fact, it is often relatively easy for corporations to exert influence on the policymaking process at the supranational level due to the proliferation of entry points that exist into supranational decision making processes, such as those of the EU.[360]

Consequently, 'there is an increasing need to establish global norms, both legally binding and non-binding, across many spheres to balance otherwise unrestrained influences of powerful actors'.[361] A single Member State is not in a position to prevent a multinational corporation from acting in a particular way in another Member State, or at the supranational level. Furthermore, each Member State may attempt different (and potentially ineffective) ways of preventing that behaviour in their own territories. To take advertising as an example again, some Member States favour a self-regulatory approach and others a legislative approach, yet a legislative approach is supported by

[353] R Beaglehole and D Yach, 'Globalisation and the prevention and control of non-communicable disease: the neglected chronic diseases of adults' (2003) 362 Lancet 903, 904.
[354] See: S Casswell, 'Current status of alcohol marketing policy – an urgent challenge for global governance' (2012) 107 Addiction 478, 480.
[355] K Smith et al, '"Working the system" – British American Tobacco's Influence on the European Union Treaty and its implications for policy: An analysis of Internal tobacco industry documents' (2010) 7(1) PLoS Medicine e1000202.
[356] On the cross border dimension of health hazardous products, see for example: A Gilmore et al, 'Free trade versus the protection of health: the examples of alcohol and tobacco' in M McKee et al, *Health Policy and European Union Enlargement* (Maidenhead: Open University Press 2004), 198.
[357] Gilmore et al, n 294 above, 2.
[358] Moodie et al, n 212 above, 672.
[359] For analysis of corporate tactics being applied at the national level, see for example: B Hawkins et al, 'Alcohol industry influence on UK alcohol policy: a new research agenda for public health' (2012) 22(3) Critical Public Health 297. For analysis of corporate tactics being applied at EU level, see for example: H Costa et al, 'Quantifying the influence of the tobacco industry on EU governance: automated content analysis of the EU Tobacco Products Directive' (2012) 23 Tobacco Control 473.
[360] P Bouwen, 'Corporate lobbying in the European Union: the logic of access' (2002) 9(3) Journal of European Public Policy 365.
[361] Beaglehole and Yach, n 353 above, 906.

evidence as being effective.[362] With a choice available, multinational corporations can rely on their rights of establishment within the European Union in order to advertise in all Member States in accordance with the rules of the least restrictive Member State. In this situation, the ability of a supranational regulator to set common rules would be a distinct advantage in tackling a factor of the addictiogenic environment that is able to move from one Member State to another in search of the most favourable regulatory conditions. Therefore, where the cross-border activities of multinational corporations are concerned, the EU is in fact in a better position to be able to put in place supranational standards that control those activities wherever the corporation responsible for them might operate. In such a situation, allocating competences to the EU to achieve exactly this would be a move to support the Member States in protecting the health of their populations.

A further reason for allowing the EU to contribute to addiction policy is that, in order to tackle many factors of the addictiogenic environment, the possible conflicts between national policies and supranational rules will need to be resolved at the supranational level. Member States cannot ignore that fact that the internal market, while it serves their economic interests well, can sometimes be an obstacle to social and public health interests. Many potential objects of addiction, especially products such as alcohol and unhealthy foods, are perceived as ordinary commodities and services, [363] trade in which provides significant economic gains to many Member State economies.[364] Consequently, any policy that seeks to restrict the promotion, availability or attractiveness of these objects will have to be reconciled with its trade restrictive effects. If the trade restrictive effects of addiction policies are considered too great, the policy may not be permitted to stand at all, under internal market law. A recent example of Member State efforts to protect public health coming into conflict with EU internal market law is the Scotch Whisky case, in which Scottish legislation setting a minimum price per unit at which alcoholic beverages could be sold was held to conflict with internal market rules on the free movement of goods, and to be potentially disproportionate the public health objectives pursued, on the basis that less restrictive means of achieving those objectives were available.[365] This is a good illustration of how, at present 'health policies … are scrutinized themselves in terms of their compliance with and contribution to industry, trade and economic policies'.[366]

[362] See: Anderson et al, n 156 above, 2235.
[363] See Babor et al n 112 above.
[364] See statistics on export and import values of various product and services available at www.trademap.org.
[365] Case C-333/14 *Scotch Whisky Association* [2015] ECLI:EU:C:2015:845.
[366] Sihto et al, n 113 above, 10.

As a supranational organisation, the EU is well placed to identify situations in which the adoption of evidence based addiction policies may conflict with the rules protecting free movement within the internal market – and to remove the possibility for conflict between national and supranational rules – by placing the control of the addictiogenic environment at the supranational level. Granted, this may not always be possible when the exact nature of the evidence based measure to be adopted is in dispute. However, where there is no dispute as to the nature of the action that should be taken, placing certain commonly pursued addiction interventions beyond the conflict of norms involved in balancing national public health and social legislation with the free trade objectives of the EU would enable progress to be made in addiction prevention. Since only the EU is in a position to address such conflicts of norms, there is a strong case for allowing the EU to take a more active role on public health issues such as the prevention of addiction.

The arguments for and against EU involvement in addiction policy are both strong, yet there is a compelling case that many factors of the addictiogenic environment simply cannot be tackled effectively by Member States acting alone. This being the case, the Treaty itself supports the involvement of the EU in public health and social matters where they could add real value. The principle of subsidiarity, often cited by the Member States in order to keep the EU out of public health and social matters, conversely supports EU action where Member State action is not sufficient to achieve the desired objectives. It is contained in Article 5(3) of the Treaty on European Union, and states that:

> 'Under the principle of subsidiarity, in areas which do not fall within its exclusive competence, the Union shall act only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States … but rather, by reason of the scale or effects of the proposed action, be better achieved at Union level'.

According to a dynamic interpretation of the subsidiarity principle – and such an interpretation is encouraged by the Protocol on Subsidiarity and Proportionality annexed to the Treaties[367] – the EU should act where it is demonstrably in a better position to the Member States to act, which is the case when it comes to factors of the addictiogenic environment that are transnational in nature, which cannot be effectively tackled by any one Member State acting alone, and in fact may be exacerbated by Member States taking divergent action. The EU therefore not only should, but must,

[367] Protocol No 30 on the application of the principles of subsidiarity and proportionality [1997] OC C 321 E, 29.12.2006, 308, para 3.

be involved in helping the Member States to tackle transnational factors of the addictiogenic environment, if these factors are to be addressed effectively.

III. EU competence for action on addiction issues

A. Introduction

The previous section argued that, despite legitimate concerns that the EU should not be involved in the making of public health or social policy on account of potential insensitivities to cultural idiosyncrasies and lack of expertise, there are certain areas of addiction policy where the EU could in fact add value to the efforts of the Member States to control the factors of the addictiogenic environment. In such areas – where transnational factors of the addictiogenic environment are concerned – EU action is not only desirable but necessary.

However, as highlighted above, the EU operates on the basis of conferred powers, meaning that EU policymakers cannot simply act in any way they please in order to tackle transnational factors of the addictiogenic environment. Under Article 5(2) of the Treaty on European Union:

> 'under the principle of conferral, the Union shall act only within the limits of the competences conferred upon it by the Member States in the Treaties to attain the objectives set out therein. Competences not conferred upon the Union in the Treaties remain with the Member States.'

Thus, despite there being a clear rationale for EU involvement in addiction policy, actual intervention can only take place within the limits of the EU's conferred powers.

This section will analyse the competences of the EU that would allow it to contribute to addiction policy. The analysis will seek to show that some of these competences contain more power than might be first thought, meaning that the EU not only has the reason but the means to provide useful and effective support to the Member States as they seek to control addiction development.

The analysis below will consider three fields of EU competence that could be used to provide the legal basis for EU action on the addictiogenic environment. The first section below will explore the EU's competence in the field of public health, contained in Article 168 TFEU. The second section will consider the EU's competence in the field of social protection, contained in Articles 151 TFEU and

153 TFEU. The final section will examine the EU's internal market competence contained in Article 114 TFEU.

B. Article 168 TFEU – Public Health

i. The development of the EU's public health competence

The health of the public had been a concern of EU political activity for many years before the EU was formally given a competence in public health. As Greer points out, health ministers had been meeting at EU level since the 1970s, and a number of EU level programmes had been set up,[368] for example the Europe Against Cancer Programme.[369] The EU was first given competence to act in the field of public health in the Maastricht Treaty,[370] which entered into effect in 1993. Article 129 EC provided the EU with a complementary competence to encourage 'cooperation between the Member States … and, if necessary, lend support to their actions' in the field of public health. The granting of this competence was viewed at the time as either 'setting limits to the expansion of EU level activities in the public health field'[371] or as 'little more than a formalization of earlier arrangement'.[372] In any event, Article 129 EC 'represented a compromise between those governments of Member States who did not want any EU mandate in health, and those who wanted to go further'.[373]

The BSE crisis provided impetus for the revision of the public health competence at the Amsterdam Treaty.[374] As a result of the 'strong desire of the Member States and the Community institutions not to repeat the errors made in the BSE affair',[375] Article 152 EC was introduced into the Treaty, which now required that all policies at EU level 'ensure' rather than just 'contribute to' a high level of human health protection.[376] The reforms introduced at Amsterdam however were small, and no new substantive powers relevant to the control of factors of the addictiogenic environment were given to the EU.

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[368] Greer, n 340 above, 138.
[369] Decision 88/351/EEC of the Council and Representatives of the Governments of the Member States of 21 June 1988 adopting a 1988 to 1989 plan of action for an information and public awareness campaign in the context of the 'Europe against cancer' programme [1988] OJ L160/52.
[370] Consolidated Version of the Treaty on European Union (Maastricht Treaty) [2002] OJ C 325, 24.12.2002, 5.
[371] T Hervey, 'Mapping the contours of European Union health law and policy' (2002) 8(1) European Public Law 69, 72.
[372] McKee et al, n 336 above, 267.
[373] Hervey, n 371 above, 72.
[374] Treaty of Amsterdam Amending the Treaty on European Union [1997] OJ C 340, 10.11.97, 1.
[375] E Vos, 'EU food safety in the aftermath of the BSE crisis' (2000) 23 Journal of Consumer Policy 227, 235.
[376] Article 152(1) EC.

This did occur in the most recent update to the public health competence, which was made by the Lisbon Treaty.[377] Article 168 TFEU remains complementary in nature, however an interesting addition was made from the perspective of addiction governance. Article 168(5) TFEU adds a specific power to adopt measures in relation to alcohol and tobacco, and is 'the first explicit reference to tobacco and alcohol ever made in the EU treaties'.[378] It therefore provides a legal basis for the EU to act directly on matters of addiction prevention that are related in some way to alcohol and tobacco control. This has gone some way to closing the competence gap that exists between the EU's formal powers in the field of public health and its policy ambitions, even if not fully closing it.[379]

ii. The complementary nature of Article 168 TFEU

Article 6 TEU lists 'protection and improvement of human health' among the areas of complementary Union competence, and Article 168(1) TFEU states that the Union action in the field of public health 'shall complement national policies'. According to Working Group V of the European Convention, which was working on drafting the Constitutional Treaty in 2002, the nature of powers currently known as complementary competences (the Working Group proposed renaming them 'supporting measures') are 'treaty provisions giving authority to the Union to adopt certain measures of low intensity with respect to policies which continue to be the responsibility of the Member States'.[380]

The fact that the powers given to the EU in public health are complementary in nature appears to confirm 'the primacy of the responsibility of the [M]ember [S]tates'[381] in fields such as addiction policy. Accordingly, some have argued that 'there is very limited room for manoeuvre in public health law at Union level'.[382] However, the fact that the powers granted by Article 168 are complimentary do not necessarily limit what the EU can contribute to addiction policy at the supranational level. Article 168 TFEU permits actions of low intensity, but there is nothing to suggest that actions of low intensity cannot be of high effectiveness.

[377] Consolidated Version of the Treaty on the Functioning of the European Union [2012] OJ C 326, 26.10.2012, 47.
[378] Alemanno and Garde, n 142 above, 1760.
[379] O Bartlett, 'The EU's competence gap in public health and non-communicable disease policy' (2016) 5(1) Cambridge Journal of International and Comparative Law 50, 52.
[380] Final Report of Working Group V 'Complementary Competencies' (2002) CONV 375/1/02, 3 <http://european-convention.europa.eu/pdf/reg/en/02/cv00/cv00375-re01.en02.pdf> accessed 30 May 2016.
[381] S Gevers, 'Health Law in Europe: From the Present to the Future' (2008) 15 European Journal of Health Law 261, 268.
[382] A Faeh, 'Obesity in Europe: The Strategy of the European Union from a Public Health Law Perspective' (2012) 19 European Journal of Health Law 69, 86.

iii. The potential of Article 168(5) TFEU for EU addiction policy.

Article 168(5) TFEU, as stated above, contains the first specific reference to alcohol and tobacco that has occurred in the Treaties. It states that:

> 'The European Parliament and the Council, acting in accordance with the ordinary legislative procedure (...) may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges (…) and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States'.

Article 168(5) TFEU potentially gives the EU a useful source of power for acting in the field of addiction prevention. Not only are alcohol and tobacco specifically flagged as objects that the EU has a mandate for acting on, but the provision generally gives power to act in order to 'combat the major cross-border health scourges'. Multinational corporations whose actions constitute vectors of disease and factors of the addictiogenic environment are just such a cross-border threat to health, for example. Thus, the potential of Article 168(5) TFEU as a legal basis that could provide the foundation for the EU to engage in the control of supranational factors of the addictiogenic environment should be examined carefully.

a. Incentive measures

Understanding the meaning of 'incentive measures', and the difference between those and 'measures', which are also referred to in Article 168(5) TFEU, is key to unlocking the potential of this provision for EU action on addiction. Examination of the development of the provision shows that inclusion of both terms is the result of imprecise drafting, and that within Article 168(5) TFEU they both refer to the same thing. Article 152(4)(c) EC of the Nice Treaty – the precursor to Article 168(5) TFEU – used only the term 'incentive measures' and excluded harmonisation. Other provisions within the public health competence that did not exclude harmonisation referred to 'measures'. Fast forward to the Lisbon Treaty, and Article 168(5) TFEU still refers to 'incentive measures' and still excluded harmonisation, and other provisions – for example Article 168(4)(a)-(c) TFEU – only refer to 'measures', and contain as specific derogation from complementary competence to permit harmonisation. Clearly, two levels of intensity of action are maintained still in the public health competence – acts of higher intensity that envisage harmonisation, and acts of a lower intensity that

do not. Article 168(5) TFEU is clearly intended to confer powers of low intensity, and thus we should not be confused by reference to two apparently different types of power.

Low intensity 'incentive measures' have been argued to only confer the ability to adopt non-binding acts, however there is nothing in the provision to prevent incentive measures being Regulations or Decisions – indeed the 'ordinary legislative procedure' is envisaged – in which case incentive measures could be binding. Grimonprez points out that if a European incentive measures is designed to encourage certain behaviour by actors within the Member States, then 'Member States may be obliged, first, to adapt their legislation so that beneficiaries can satisfy the conditions'[383] that are necessary in order to take advantage of the incentive offered. This does not amount to harmonisation of Member State laws through the back door – harmonisation substitutes Member State for European control over the direction of certain aspects of policy, and in the scenario above 'there is no pre-emption. Member States keep their basic competence … but they have to exercise it in compliance with EU law containing incentive measures'.[384] As Hervey explains, if a European measure requires compliance with 'procedural obligations to report within certain timeframes [or] provide information within certain parameters', there is no substitution of the basic Member State prerogative to direct policy within the policy field.[385]

Incentive measures offer several advantages over traditional command-and-control legislation. They are 'ethically less problematic than coercive measures',[386] making them simpler to justify in sensitive policy fields. Incentive measures offer policy makers lower contracting costs, are able to accommodate diversity, are flexible, can be adopted quickly, and offer the possibility for incrementalism.[387] An example of a strong incentive is a financial incentive – 'public health will always turn on allocational decisions',[388] so giving actors enough financial incentive to choose approaches that will benefit public health is one powerful way to influence the direction of public health policy. Hervey points out that 'although the EU's budget is modest, the EU institutions have traditionally used the provision of financial incentives to promote the integration process',[389] and if the EU can use its own money as an incentive, or incentivise other actors to use theirs, the EU can

[383] K Grimonprez, 'The European Dimension in Citizenship Education: Unused Potential of Article 165 TFEU' (2014) 39 European Law Review 3, 12
[384] ibid, 12.
[385] T Hervey, 'The European Union and the Governance of Health Care' in G de Burca and J Scott (eds), *Law and New Governance in the EU and the US* (Oxford: Hart 2006), 197.
[386] Kass, n 327 above, 1780.
[387] These advantages are summarised in: D Trubek et al, '"Soft Law", "Hard Law" and EU integration' in G de Burca and J Scott (eds), *Law and New Governance in the EU and the US* (Oxford: Hart 2006) 73 – 74.
[388] L Gostin, *Public Health Law: Power, Duty, Restraint* (University of California Press 2008) 493.
[389] Hervey, n 385 above, 198.

act as a 'supranational policy entrepreneur to cultivate shifts towards a particular idea'[390] in the addiction field. In summary, 'people respond to incentives'[391] and therefore 'understanding the incentives of all the players in a given scenario'[392] can make incentive measures adopted under the legal basis provided by Article 168 TFEU, even if non-binding, a powerful tool through which the EU could discharge its supranational responsibilities on addiction.

b. Prohibition of harmonisation

Understanding what is covered by the prohibition on harmonisation in Article 168(5) TFEU is also crucial to unlocking the potential of this provision for EU action on addiction. There are two ways in which the phrase 'excluding any harmonisation of the laws and regulations of the Member States' could be interpreted. First, the wide interpretation, which is that EU law 'must not modify existing national public health legislation'.[393] A wide view of harmonisation is that EU laws will 'not merely displace but replace individual national political choices'.[394] Second, the narrow interpretation, which is that EU law must not constitute the purposeful 'de jure'[395] homogenisation of national rules. This narrower view of harmonisation means that if EU law has the 'indirect effect of harmonizing … [this] does not necessarily mean that it conflicts with the prohibition on harmonization'.[396]

The wider understanding is supported by the case law of the CJEU. In *UK v Parliament and Council*, harmonisation was understood as 'measures for the approximation' of national laws, following the letter of the Treaties.[397] Furthermore, in the recent *Poland v Parliament and Council* judgement, it was held that 'by using the words "measures for approximation" … The authors of the Treaty intended to convey on the EU legislature a discretion, depending on the general context and the specific circumstances of the matter to be harmonized, as regards the methods of approximation most appropriate for achieving the desired result, in particular in fields with complex technical features'.[398] In light of these judicial statements, we should understand harmonisation to mean a

[390] A Batory and N Lindstrom, 'The Power of the Purse: Supranational Entrepreneurship, Financial Incentives, and European Higher Education Policy' (2011) 24(2) Governance 311, 312.
[391] S Levitt and S Dubner, *Think Like a Freak* (Penguin 2015), 106.
[392] ibid.
[393] R Schütze, 'Cooperative Federalism Constitutionalised: The Emergence of Complementary Competences in the EC Legal Order' (2006) 31(2) European Law Review 167, 181.
[394] M Dougan, 'Legal Developments' (2010) 48 Journal of Common Market Studies 163, 178.
[395] Schütze, n 393 above, 181.
[396] K Lenaerts, 'Subsidiarity and Community Competence in the Field of Education' (1994) 1 Columbia Journal of European Law 1, 15.
[397] Case C-66/04 *United Kingdom v Parliament and Council* [2005] ECLI:EU:C:2005:743, para 45.
[398] Case 358/14 *Poland v Parliament and Council* [2016] ECLI:EU:C:2016:323, para 37

process that encompasses various methods, whether direct or indirect in their effect, of substituting national legislative initiative for that of EU legislative initiative. Thus, the prohibition on harmonisation (what cannot be done) is consistent with the understanding of what incentive measures entails (what can be done) – the overall position is therefore that Article 168(5) TFEU provides legal basis for any EU act that seeks to organise or incentivise the way in which Member States adopt laws relating to addiction, but does not provide legal basis for any EU action that would seek through any means to remove control over a particular substantive policy decision from the Member States. That power must be found elsewhere in the Treaties.

iii. Summary

The above analysis shows that Article 168(5) TFEU could provide sufficient power for the EU to be able to take a range of non-harmonising actions that organise and guide the activates of the Member States in addiction policy. While the public health competence cannot provide the legal basis for setting common EU standards, it can act as the legal basis for the creation of strategic plans, the allocation of EU funds, the issuing of recommendations and the convening of forums, all of which, if employed in order to support and inform the application of more coercive interventions in order to enhance their effectiveness, are options for EU contribution that should not be ignored. The fact that the EU has responsibilities in addiction governance does not mean that the EU must necessarily discharge these responsibilities through legislative action[399] – it means that the EU has a responsibility to discharge certain functions of addiction governance that cannot otherwise be achieved by the Member States. If these functions can be achieved through Article 168 TFEU, then the powers it provides should not be neglected, on the misplaced belief that complimentary competences offer little power to the EU.

C. Article 153 TFEU

i. The development of the EU's social competences

The EU's social competence has evolved to be one of the 'most complex competences within the Treaties'[400] – therefore understanding its development will better aid an understanding of how it might be expected to underpin EU intervention in addiction governance. An embryonic social competence – more a social aspiration[401] resulting from market integration spill-over[402] – was

[399] K Armstrong, 'EU social policy and the governance architecture of Europe 2020' (2012) 18(3) Transfer 286, 291.
[400] R Schütze, *European Union Law* (Cambridge University Press 2015), 816.
[401] P Kettunen and C Wolff, 'Europeanisation through the Back Door: EU Social Policy and the Member States' (2011) 47(5) Politička misao 144, 148.

included in Article 117 EEC of the Treaty of Rome[403] with the sole purpose of creating a European labour market.[404] The initial reluctance of the founding Member States to include social standards in the European integration project[405] created a 'political decoupling of economic integration and social-protection issues',[406] that successive Treaty amendments have found difficult to piece back together.

The first explicit EU social competence came in the Single European Act of 1986, however no powers relating to social protection were included. Progress slowed when the Community Charter of Fundamental Social Rights of Workers 1989[407] had to be excluded from the 1992 Maastricht Treaty due to UK opposition, and was instead annexed to the Treaty as a Protocol on Social Policy.[408] The formal powers of the EU therefore remained unchanged, reflecting the continuing 'refusal of Member States to countenance an amendment to the Treaties that would result in the establishment of a broad EU competence in the field of social welfare'. [409]

A change in UK government in 1997 broke the political deadlock over EU social policy, facilitating the inclusion of the 1989 Charter along with the 1961 European Social Charter[410] in the Treaty of Amsterdam in 1997.[411] Amsterdam also updated the objectives of the European Economic Community to include 'a high level of employment and social protection … [and] the raising of the standard of living and quality of life',[412] and introduced Articles 136 and 137 EEC. Despite this progress, the EU's legal competence was still restricted to supporting and complementing the

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[402] v Maydell et al, n 336 above, 23.
[403] Treaty Establishing the European Economic Community (Rome Treaty) (signed 25 March 1957), Article 117.
[404] v Maydell et al, n 336 above, 23.
[405] Scharpf, n 335 above, 646.
[406] Ibid.
[407] Community Charter of Fundamental Social Rights of Workers 1989, European File 6/90.
[408] J O'Connor, 'Policy coordination, social indicators and the social-policy agenda in the European Union' (2005) 15(4) Journal of European Social Policy 345, 347.
[409] N Bernard, 'Between a rock and a soft place: Internal market vs open coordination in EU social welfare law' in M Dougan and E Spaventa (eds), *Social Welfare and EU Law* (Oxford: Hart 2005), 262.
[410] The European Social Charter is the counterpart to the European Convention on Human Rights, and grants a broad range of social rights, including Article 7 on the special protection of children against physical and moral dangers, Article 11 on the right to protection of health, and Article 30 on the prevention of social exclusion. European Social Charter, (opened for signature 18 October 1961, entered into force 26 February 1965) European Treaty Series Number 035. The Charter was revised in 1996: Council of Europe, European Social Charter (Revised), 3 May 1996, ETS 163.
[411] O'Connor, n 408 above, 348.
[412] Article 2 Amsterdam Treaty.

Member States in building the European labour market,[413] demonstrating that the Member States were still 'ambivalent'[414] towards the role of the EU in social protection policy.

In March 2000 however, the Lisbon European Council committed the EU to becoming 'the most competitive and dynamic knowledge-based economy in the world capable of sustainable economic growth with more and better jobs and greater social cohesion', and to 'ensuring that the emergence of this new economy does not compound the existing social problems of unemployment, social exclusion and poverty'.[415] This 'crucial point'[416] for EU social policy 'attempted to rebalance the economic and social dimension',[417] of EU policymaking, and consequently the Nice Treaty of 2000 finally updated the EU's social competence to include powers in fields including social security, the combatting of social exclusion and the modernization of social protection systems.[418]

Despite these additions, it is arguable that the Lisbon Summit did more to entrench economic biases than to resolve them. It described Europe's people as its 'main *asset*', while suggesting that social exclusion can be tackled 'by creating the economic conditions for greater prosperity'.[419] Moreover, the emphasis was on ensuring that the 'new economy does not compound the existing social problems',[420] rather than on ensuring that the pursuit of social protection will not hinder economic development. This subtle re-entrenchment of social policy as an agent of productivity indicates that the Lisbon Summit did not particularly change anything.[421] As Armstrong points out 'a decade on [after the Lisbon Summit] … joblessness was on the rise and social cohesion strained'.[422] The so-called Lisbon agenda was subsequently revised in 2005 and the work on social inclusion and protection was suspended.[423] Despite the rhetoric, the Lisbon Treaty of 2007 left the EU's formal

[413] See M Ferrera et al, 'Open coordination against poverty: the new EU 'social inclusion process' (2002) 12(3) Journal of European Social Policy 227, 229.
[414] M Daly, 'EU Social Policy after Lisbon' (2006) 44(3) Journal of Common Market Studies 461, 468.
[415] Presidency Conclusions of the Lisbon European Council 23 and 24 March 2000, available online at http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:c10241 (last accessed 24 August 2016).
[416] Bernard, n 409 above, 277.
[417] E Szyszczak 'The new paradigm for social policy: a virtuous circle' (2001) 38 Common Market Law Review 1125, 1140.
[418] Article 137(1) subparagraphs (c), (g), (j) and (k) respectively, Treaty of Nice 2000.
[419] Presidency Conclusions of the Lisbon European Council 23 and 24 March 2000, available online at http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:c10241 (last accessed 24 August 2016), emphasis added.
[420] Presidency Conclusions of the Lisbon European Council 23 and 24 March 2000, available online at http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:c10241 (last accessed 24 August 2016), para 24.
[421] Daly, n 414 above.
[422] Armstrong, n 399 above, 286.
[423] For an analysis of how the Lisbon Agenda developed after the Lisbon Summit in 2000, see: Armstrong, n 399 above.

competences in social policy unchanged from Nice,[424] arguably confirming the stagnation of EU social policy,[425] and doing 'little to bolster the EU's social policy toolkit'.[426] This must be seen as a product of the continuing position that 'the member States do not wish to delegate control and thus prefer a scheme of "soft" and flexible cooperation to "hard" legislation'.[427] Consequently, it may be far more difficult to extract power for EU action on transnational factors of the addictiogenic environment from the EU social competences than is the case for the public health competence.

ii. The nature of the EU's social competences

While the EU's current public health competence is distinctly complimentary in nature, the EU's current social competence cannot be so easily categorised. Some aspects of social policy are subject to shared competence. Article 4(2)(b) states that 'social policy, for the aspects defined in this Treaty' will be a shared competence of the EU. Looking to the objectives of social policy as set out in Article 151 TFEU that are relevant to addiction policy, 'the Union and the Member States … shall have as their objectives … proper social protection …and the combating of exclusion'. It furthermore states that 'to this end the Union and the Member States shall implement measures which take account of the diverse forms of national practices … and the need to maintain the competitiveness of the Union's economy'. These definitions are vague and, as Craig notes, harmonisation is mentioned 'in guarded tones'.[428] Examining the detailed list of EU social powers set out in Article 153 TFEU does not help either, as this Article too does 'not provide explicit guidance as to which areas fall within shared competence, and which do not'.[429]

Articles 153(1)(j) and (k) TFEU confer a power on the Union to 'support and complement the activities of the Member States' in the fields of social exclusion and the modernisation of social protection systems respectively – both fields in which the EU could make important contributions to addressing social dislocation factors of the addictiogenic environment. Although social policy is prima facie an area of shared competence, these particular provisions appear to confer no such power. They are excluded from the fields in which the EU may adopt 'by means of directives, minimum requirements for gradual implementation'.[430] Furthermore, the language of Article 153 TFEU, which permits the EU to 'support and complement' the Member States, 'does not fit naturally

[424] P Craig, *The Lisbon Treaty: Law Politics, and Treaty Reform* (Oxford University Press 2010), 323-324.
[425] See M Korda and P Schoukens, 'The EU Constitution: What went wrong for "social protection"?' (2006) 8 European Journal of Social Security 7, 15.
[426] Armstrong, n 399 above, 298.
[427] Kettunen and Wolff, n 401 above, 148.
[428] Craig, n 424 above, 169.
[429] ibid.
[430] Article 153(2)(b).

with shared competence',[431] hinting instead that such powers are, instead, complimentary. Thus, the EU's competence to act in the fields of social exclusion and the modernisation of social protection systems does not appear to be a shared competence.

These powers may instead be coordinating competences, which confer powers on the EU to 'provide "arrangements" for the Member States to exercise their competences in a coordinating manner'.[432] This, however, is unlikely. Although Article 5(3) TFEU states that 'The Union may take initiatives to ensure coordination of Member States' social policies', the list of coordinating competences in Article 2(3) TFEU does not include social policy. As Armstrong points out, the fact that the EU shall coordinate only economic and employment policy according to Article 2(3), but *may* also ensure the coordination of Member States' social policy according to Article 5(3) TFEU, is a by-product of two things: the Member States' historic unwillingness to formally divest any further social powers to the EU, but their recognition of the Lisbon Agenda's vision for European coordination of social policies through governance instruments such as the Open Method of Coordination.[433] Thus, Article 5(3) TFEU represents a compromise over the formal consitutionalisation of the Open Method of Coordination as a tool of EU competence,[434] yet does not confer upon the EU the right to control the coordination of Member State social policies. In any event, if it is accepted that 'the adoption of Union acts resulting in some degree of harmonisation would be constitutionally permitted'[435] under a coordinating competence, then the powers conferred in Article 153(1)(j) and (k) cannot be coordinating competences. This is because harmonisation of the Member State's social policies is absolutely precluded, both formally according to Article 153(2)(a), which states that the EU may adopt measures 'excluding any harmonisation of the laws and regulations of the Member States', and on a practical level by virtue of the fact that 'the present diversity of national social-protection systems and the political salience of these differences make it practically impossible for them to agree on common European solutions'.[436]

The EU's powers in the field of social exclusion and the modernisation of social protection systems must therefore be seen as complimentary competences, despite the fact that social policy is not

[431] Craig, n 424 above, 170.
[432] R Schutze, *European Constitutional Law* (Cambridge University Press 2012), 167.
[433] Armstrong, n 399 above, 292.
[434] For a discussion of this compromise, see: J Zeitlin, 'Social Europe and Experimentalist Governace: Towards a New Constitutional Compromise?' in G de Burca (ed), *EU Law and the Welfare State: In Search of Solidarity* (Oxford University Press 2005), 236-241.
[435] Schütze, n 400 above, 242.
[436] Scharpf, n 335 above, 652.

listed in what appears to be a finite list of such competence in Article 6 TFEU.[437] However 'when reading the TFEU as a whole … it becomes clear that there are other important areas in which the EU is limited … to supporting etc action'.[438] It can therefore be argued that Articles 153(1)(j) and (k) TFEU are complimentary in nature. Article 153 TFEU opens with the statement that the EU 'shall support and complement the activities of the Member States' in the fields therein. Furthermore, according to Article 5(2) TEU, 'competences not conferred upon the Union in the Treaties remain with the Member States' – if exclusive, shared or coordinating competences are not conferred by Articles 153(1)(j) and (k) TFEU, then primary competence in those fields must remain with the Member States, leaving any powers that are conferred as complimentary, since such powers by virtue of Article 2(5) TFEU must be exercised 'without thereby superseding [Member State] competence in these areas'. Finally, Articles 153(1)(j) and(k) TFEU do not confer the power to adopt directives or harmonisation measures according to Article 153(2)(a) TFEU, and cannot 'affect the right of the Member States to define the fundamental principles of their social security systems and must not significantly affect the financial equilibrium thereof', therefore meaning that they will not permit the creation of common standards.

It therefore appears that the EU's competences in the fields of social exclusion and the modernisation of social protection systems are, as with its competences in public health, complimentary in nature. The EU will therefore be able to contribute to addiction governance in these fields through action that supports but does not replace the activities of the Member States. In order to understand how this contribution could be maximised, it will be necessary to examine the primary legal tool that has been developed for the exercise of EU social competences, the Open Method of Coordination (OMC), and it is to an analysis of what OMC processes can contribute to the control of factors of the addictiogenic environment that we now turn.

iii. The Open Method of Coordination – the EU's social competence tool

Unlike the EU's public health competence, Article 153 is more explicit in defining the actions that the EU is permitted to take under its complimentary competence. Article 153(2)(a) states that the Parliament and Council 'may adopt measures designed to encourage cooperation between Member States through initiatives aimed at improving knowledge, developing exchanges of information and best practices, promoting innovative approaches and evaluating experiences'. The tool envisaged for the implementation of such measures was the OMC.

[437] Craig, n 424 above, 174.
[438] ibid.

The OMC was created in order to reconcile the need to promote the constitutional equality of economic and social imperatives with the need to work within the constraints imposed by the diversity of European social systems. As Ferrera explains,[439] the increasing desire for cooperation in and improvement of social protection in Europe led to the Commission requesting the extension of OMC processes (the foundations for which were laid by the Maastricht and Amsterdam Treaties in relation to economic and employment policy[440]) to social exclusion through two Communications.[441] The Commission noted the growing intent of the Member States to promote inclusion, that 'the European Union wishes to make a political commitment to this end' and that this could be achieved through 'open forms of cooperation between Member States rather than … [through] a heavy coordination process'.[442] The OMC was duly extended to social inclusion at the Lisbon Summit, which proclaimed that 'policies for combating social exclusion should be based on an open method of coordination combining national action plans and a Commission initiative for cooperation'.[443] Thus an OMC was established in the social exclusion field, yet was not given a Treaty basis at Lisbon to match those for economic and employment policy.

The label 'OMC' in fact describes a variety of processes that provide an organisational framework for the activities of the Member States.[444] In essence it is 'an experimentalist approach to EU governance based on iterative benchmarking of national progress towards common European objectives and organised mutual learning'.[445] Each OMC process can be slightly different in emphasis, content and goals, however will share two basic characteristics: 'policy choices remain at the national level and European legislation is explicitly excluded'.[446] An OMC process typically aims to encourage the convergence of Member State policy towards a common standard through a combination of common indicators, national and subnational targets and policies, the setting of implementation timetables, exchange of best practice, progress monitoring, periodic reporting, and peer review.[447] The purpose of OMC is thus to act as 'a cognitive and normative tool for defining and

[439] See Ferrera et al, n 413 above, 229-230.
[440] Articles 98-104 TEC and Article 125-128 TEC respectively. See: Scharpf, n 335 above, 652.
[441] Communication Communication on A concerted strategy for modernising social protection, COM(1999) 347 final; Commission Communication on Building an inclusive Europe, COM(2000) 79 final.
[442] See Commission Communication on Building an inclusive Europe, COM(2000) 79 final, para 15.
[443] Presidency Conclusions of the Lisbon European Council 23 and 24 March 2000, available online at http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:c10241 (last accessed 24 August 2016), para 32.
[444] See Zeitlin, n 434 above, 217-218.
[445] J Zeitlin, n 434 above), 217-218.
[446] Scharpf, n 335 above, 652.
[447] For more detailed summaries of how OMC processes function, see for example: Ferrera et al, n 413 above; C de la Porte, 'Is the Open Method of Coordination Appropriate for Organising Activities at European Level in Sensitive Policy Areas?' (2002) 8(1) European Law Journal 38; Daly, n 414 above.

building consensus around a distinctive "European" (or perhaps more accurately "EU") "Social Model" and policy paradigm based on shared values and objectives'.[448] It is therefore unsurprising that this mode of policy making was seized upon to break the political impasse over how the EU should contribute to policymaking on social exclusion.[449]

OMC processes offer several opportunities for addiction policymaking. Primarily, OMC processes offer a method of promoting common social solutions to common social problems where there is no formal EU power to harmonise. OMCs are attractive in these situations on account of being 'a mechanism that may help to solve pressing national socioeconomic issues … without mandating conformity in commitments or mode of implementation'.[450] Engaging with OMCs is appealing for states because it is an alternative to doing nothing in sensitive fields, where pressure nonetheless exists to do *something*.[451] Furthermore, an OMC process 'transcends the dichotomies of national vs. European and formal vs. informal policymaking'[452]. It is an option in sensitive social policy areas, such as the combatting of social dislocation, which allows Member States and EU institutions to side-step arguments over the boundaries of European competence or the application of the subsidiarity principle. Unanimous decision making is still required for the use of European competences in the social field, and thus an OMC offers an 'essential mechanism for progress'.[453] Finally, by simply encouraging and facilitating discussion among the Member States on shared problems such as the addictiogenic environment, OMC processes raise 'the political salience and ambitions of … social inclusion policies at the national as well as the EU level'[454] and contribute to 'broad shifts in national policy orientation and thinking, involving the incorporation of EU concepts and categories into domestic debates'.[455]

The OMC is not without flaws. There are no formal enforcement mechanisms to ensure that commitments made in an OMC process are actually carried out,[456] meaning that actual policy progress relies solely on the political drive of the Member States participating in the OMC.[457] Furthermore, for all the deadlock that might be relieved through an OMC process, the Member

[448] Zeitlin, n 434 above, 219.
[449] v Maydell et al, n 336 above, 70.
[450] O'Connor, n 408 above, 353.
[451] J Zeitlin, n 434 above, 221.
[452] Kettunen and Wolff, n 401 above, 151.
[453] O'Connor, n 408 above, 353.
[454] J Zeitlin, n 434 above, 229.
[455] ibid.
[456] V Hatzopoulos, 'Why the Open Method of Coordination Is Bad For You: A Letter to the EU' (2007) 13(3) European Law Journal 309, 316.
[457] O'Connor, n 408 above, 358.

States 'continue to operate under exactly the same legal and economic constraints of economic integration which limit their policy choices when they are acting individually'.[458] The OMC would be no solution to the 'constitutional asymmetry'[459] between internal market and social policy imperatives. Moreover, while OMC processes may be a way of influencing Member States to adopt common solutions to common social problems, the influence of such debates can work two ways. The Member States can exert their own influence back on the process,[460] meaning that some Member States may be pressured into making fundamental structural alterations to their social protection systems that may not be suitable or affordable for that Member State.[461]

In summary, the OMC is a process that holds promise for enabling the EU to actually use its social competences in a way that may be able to generate discussion on factors of the addictiogenic environment that promote social dislocation. It is true that there is an absence of hard data available to assess whether OMC processes are effective or not,[462] however, despite the many criticisms that the OMC has drawn in the literature,[463] it is nevertheless the case that the process is available to EU policy makers in the field of social exclusion and the modernisation of social protection systems, and has the potential to be implemented in ways that could add value to addiction policy.[464]

D. Article 114 TFEU

Articles 168 TFEU and 153 TFEU provide legal bases for the EU to take action to support the Member States in addiction policy, however neither competence supports the creation of common standards at EU level. While it was noted above that the EU's responsibilities in addiction governance do not simply mean that the EU must seek to legislate, the creation of supranational standards in response to some transnational threats to the health of European citizens should certainly be seen as one of those responsibilities, especially when it involves a conflict of norms between the national and EU level. In order to discharge these responsibilities, the EU must rely on powers other than those provided by the public health and social competences.

[458] Scharpf, n 335 above, 655.
[459] See the analysis in Scharpf, n 335 above.
[460] Kettunen and Wolff, n 401 above, 152.
[461] de la Porte, n 447 above, 56.
[462] Zeitlin, n 434 above, 227.
[463] In addition to the examples from the literature cited above, see: T Idema and D Kelemen, 'New modes of governance, the Open Method of Coordination and other fashionable red herring' (2006) 7(1) Perspectives on European Politics and Society 108.
[464] For a more positive assessment of the potential of OMC processes to bring about European solutions, see: L Tholoniat, 'The career of the Open Method of Coordination: Lessons from a 'soft' EU instrument' (2010) 33(1) West European Politics 93.

Article 114 TFEU, one of the EU's general competences, has historically been the Treaty provision relied upon in these circumstances. Article 114 TFEU provides a legal basis for the EU to harmonise Member States laws for the purpose of ensuring the smooth functioning of the internal market. Article 114(1) TFEU reads as follows:

> 'The European Parliament and the Council shall … adopt the measures for the approximation of the provisions laid down by law, regulation or administrative action in Member States which have as their object the establishment and functioning of the internal market'.

Since Article 114 TFEU grants powers specifically for the development of the internal market, it offers the EU an ideal opportunity to ensure that the development of the internal market can be reconciled with the implementation of measures that would effectively protect individuals from the influence of the addictiogenic environment. Article 114 TFEU is therefore a potentially powerful and valuable tool for tackling some of the deepest rooted and most intractable factors of the addictiogenic environment, namely the policymaking biases that prioritise the pursuit of free market ideals over the protection of health. The sections below will explore the conditions for recourse to Article 114 TFEU, and the ways in which it might be employed to control transnational factors of the addictiogenic environment.

i. Conditions for recourse to Article 114

The test for recourse to Article 114 was laid out in the now famous case of *Germany v Parliament and Council (Tobacco Advertising 1)*, in which Germany argued that the EU's internal market competence did not provide sufficient legal basis for the adoption of Directive 98/43/EC on the prohibition of tobacco advertising within the EU. The Court went to great lengths to ensure that the power granted by Article 114 TFEU will be used for internal market building rather than internal market regulation. Indeed, it asserted that 'to construe [Article 114 TFEU] as meaning that it vests in the Community legislature a general power to regulate the internal market would … be incompatible with the principle … that the powers of the Community are limited to those specifically conferred on it'.[465]

To this end, the Court set out a test that somehow managed to be both detailed in terms of the conditions that the EU legislature must fulfill, yet incredibly vague in how these conditions might be

[465] Case C-376/98 *Germany v European Parliament and Council of the European Union* [2000] ECLI:EU:C:2000:544, para 83.

interpreted. A measure seeking to rely on Article 114 TFEU must be 'intended to improve the conditions for the establishment and functioning of the internal market'.[466] It must 'genuinely have as its object the improvement of the conditions for the establishment and functioning of the internal market'.[467] And it must 'in fact [pursue] the objective stated by the community legislature'.[468] In other words, to be based on Article 114 TFEU, a measure must intend to improve the internal market, and must pursue a course of action that theoretically and practically achieves this.

In addition to the test, the Court made a number of follow up statements regarding the interpretation of the test when the measure in question has other objectives besides the building of the internal market – helpfully for our purposes, the other objective in the case was the protection of public health. The Court stated that the fact that harmonisation is excluded in Article 168(5) TFEU 'does not mean that harmonizing measures adopted on the basis of other provisions of the Treaty cannot have any impact on the protection of human health'.[469] It also stated, that provided the conditions above were met, 'the Community legislature cannot be prevented from relying on that legal basis on the ground that public health protection is a decisive factor in the choices to be made'.[470] The way in which the test for recourse to Article 114 TFEU was formulated means that it is highly probable that the EU's harmonisation powers can be used in order to control transnational factors of the addictiogenic environment, so long as some contribution is also made to removing an obstacle to free movement within the internal market. The subsection below will illustrate how the interpretation of the test following *Tobacco Advertising 1* has turned this probability into a virtual certainty.

ii. Interpretation of the conditions for recourse to Article 114

The way in which the *Tobacco Advertising* test was applied, especially in the follow up case of *Germany v Parliament and Council (Tobacco Advertising 2)* has meant that, while the Court were at pains to ensure that Article 114 TFEU did not become a floodgate provision that gave the EU competence to adopt harmonising legislation on virtually any subject, this is precisely what Article 114 TFEU has evolved into. In attempting to set conditions that would tie the use of Article 114 TFEU to internal market building, the Court actually provided a generous and malleable drafting guide[471]

[466] ibid, para 83.
[467] ibid, para 84.
[468] ibid, para 85.
[469] ibid, para 78.
[470] ibid, para 88.
[471] S Weatherill, 'The Limits of Legislative Harmonization Ten Years After Tobacco Advertising: How the Court's Case Law Has Become a "Drafting Guide"' (2011) 12 German Law Journal 827.

for the use of Article 114 TFEU to achieve objectives in virtually any policy field that has an internal market dimension.

If the CJEU were truly worried about Article 114 TFEU turning into a general regulatory power, one might think that the first line of defense against such a development – the application of general principles of EU law such as proportionality or subsidiarity – would have been pursued with greater vigour in subsequent cases. However, the application of the proportionality and subsidiarity principles by the CJEU to exercises of Article 114 TFEU has done little to constrain and more to permit the use of the internal market competence for public health purposes.

The CJEU's approach to proportionality was demonstrated in the *Swedish Match* case.[472] The Court, in upholding a total ban on the marketing of snus (an oral tobacco product), held that 'only if a measure adopted in this field is manifestly inappropriate in relation to the objective',[473] will its legitimacy be called into question. Further evidence of a light touch approach to proportionality can be seen in the more recent case of *Vodafone,* in which Article 114 TFEU was the legal basis for regulation of mobile phone roaming charges. In this case, the CJEU admitted that it has:

> 'accepted that in the exercise of the powers conferred on it the Community legislature must be allowed a broad discretion in the areas in which its action involves political, economic or social choices and in which it is called upon to undertake complex assessments and evaluations'.[474]

The CJEU here confirmed its choice to defer to the EU legislature on all political, economic or social decisions relating to how and why Article 114 TFEU should be used. With this, the value of examining whether the real reasons for the use of Article 114 TFEU are proportionate are all but eliminated. Advocate General Kokott confirmed this position in her Opinion on Poland's challenge to the revised Tobacco Products Directive, emphasising that the margin of discretion means that 'an infringement of the principle of proportionality by the Union legislature can be taken to exist only where the EU measure concerned is manifestly disproportionate'.[475] The EU accordingly 'now seems

[472] Case C-210/03 *Swedish Match v Secretary of State for Health* [2004] ECLI:EU:C:2004:802.
[473] ibid, para 48.
[474] Case C-58/08 *Vodafone v Secretary of State for Business, Enterprise and Regulatory Reform* [2010] ECLI:EU:C:2010:321, para 52.
[475] Opinion of Advocate General Kokott in Case C-358/14 *Poland v Parliament and Council* [2015] ECLI:EU:C:2015:848, para 89.

to have a broad discretion in how to exercise its broad discretion',[476] thus further reducing the limits placed on the use of Article 114 TFEU.

If the principle of proportionality cannot place limits upon the use of Article 114 TFEU, then what of the principle of subsidiarity? Since the subsidiarity principle is essentially a form of 'federal proportionality'[477] there is no reason for its application to the use of Article 114 TFEU to be any more effective than the proportionality principle. *Vodafone* confirms this – the CJEU dedicated just two paragraphs to evaluating the compliance of the contested Regulation with the subsidiarity principle, simply accepting the reasoning put forward by the EU legislature without further scrutiny, rather than attempting to actually assess the added value of Union action.[478] Advocate General Kokott confirmed this weak approach to how the subsidiarity principle is applied to the use of Article 114 TFEU – 'the Court can reasonably review only whether the Union's political institutions have kept within the limits of the discretion conferred on them in the exercise of their competences in the light of the principle of subsidiarity'.[479]

Thus, with each subsequent application, interpretation and reapplication of the test formulated in *Tobacco Advertising 1*, the EU legislature has become more adept at framing measures in terms of how they will improve the internal market, when their true purpose and effect is to further some other policy objective. The Court has seemingly also been increasingly prepared to 'find some connection between national disparities and the four freedoms so as to trigger Article 114, without too close an inquiry as to the reality of the impact on these freedoms'.[480] This cycle of interpretation has led to the development of a 'threshold so apparently low and potentially subjective as to no longer guarantee that a given proposal manifests any meaningful and demonstrable connection to the internal market'.[481]

As a result, 'providing the drafting is well-chosen, the Court has no plausible basis on which to set aside the legislative act',[482] an eventuality that has been borne out on several occasions that are relevant from the point of view of addiction policy. These shall be analysed in the final subsection

[476] Bartlett, n 379 above, 69.
[477] The idea of whether the Union has been proportionate in assessing that the EU level will be the most effective for achieving the objectives sought. See: R Schütze, 'Subsidiarity after Lisbon: Reinforcing the safeguards of federalism' (2009) 68(3) Cambridge Law Journal 525, 533.
[478] *Vodafone*, n 474, paras 76-77.
[479] Opinion of Advocate General Kokott in *Poland v Parliament and Council* n 475 above, para 146.
[480] P Craig, 'The ECJ and Ultra Vires Action: A Conceptual Analysis' (2011) 48 Common Market Law Review 395.
[481] Dougan, n 394 above, 177.
[482] Weatherill, n 471 above.

below to show how the powers granted by Article 114 TFEU could be applied to create common European standards that control transnational factors of the addictiogenic environment.

iii. Applications of Article 114 in addiction policy

The powers for public health intervention that are provided by the EU's internal market harmonisation competence are significant, and could be put to good use in discharging the responsibility that the EU has for addressing transnational factors of the addictiogenic environment. Based on the already approved uses of Article 114 TFEU, the following analysis seeks to explore the types of intervention that could realistically be made under the internal market competence.

Article 114 TFEU could be used to implement bans on the marketing of products that are traded across borders. Advertising bans were, of course, the subject of the *Tobacco Advertising* litigation itself, and the CJEU clearly indicated, even before setting out its test, that 'in principle, therefore, a Directive prohibiting the advertising of tobacco products in periodicals, magazines and newspapers could be adopted on the basis of [Article 114] of the Treaty'.[483] More stringent marketing measures have also been approved by the Court, for example in *Swedish Match*, where it was held that 'requiring all the Member States to authorise the marketing of the product or products concerned (…) or even provisionally or definitively prohibiting the marketing of a product'[484] may be an appropriate response under Article 114 TFEU. Total marketing bans were also upheld by the CJEU in *Alliance for Natural Health*[485] and *Arnold André*.[486] Consequently, one might conclude that bans on advertising, sponsorship or other forms of marketing in relation to addictive objects other than tobacco, such as alcohol or unhealthy foods, are legally possible under the powers granted by Article 114 TFEU.

Another intervention that the EU might adopt, and which has been subject to speculation in the literature, is the adoption of plain packaging for tobacco products.[487] Such an intervention has been

[483] *Germany v European Parliament and Council of the European Union*, n 465 above, para 98.
[484] *Swedish Match v Secretary of State for* Health, n 472 above, para 34.
[485] Joined Cases C-154/04 and C-155/04 *Alliance for Natural Health and Others v Secretary of State for Health* [2005] ECLI:EU:C:2005:449.
[486] Case C-434/02 *Arnold André v Landrat des Kreises Herford* [2004] ECLI:EU:C:2004:800.
[487] For discussion on the legal aspects of whether the EU might adopt plain packaging measures, see: A Alemanno, 'Out of sight, out of mind: Towards a New EU Tobacco Products Directive' (2011) 18 Columbia Journal of European Law 197; Freeman et al, n 160 above*;* A Alemanno and A Garde*, Legal opinion on the compatibility of the UK proposals to introduce standardised packaging on tobacco products with the EU Tobacco Products Directive* (ASH 2014).

highly controversial,[488] yet it is predicted that it would result in a significant reduction in the appeal of tobacco products, thus making it a prime candidate for inclusion in addiction policy. Its adoption at EU level would rely on the EU legislature establishing that there is a barrier to internal market operation resulting from disparities between the Member State's approaches to tobacco regulation, or the risk of significant distortions of competition from these approaches, and that mandating plain packaging is a proportionate response. Following the judgements in *Poland v Parliament and Council* and *Phillip Morris v Secretary of State for Health*[489] from the CJEU and *British American Tobacco and Secretary of State for Health*[490] from the UK High Court, the legality of EU legislation on plain packaging has received a significant boost. In *Poland v Parliament and Council* and *Philip Morris* the CJEU confirmed that Article 114 TFEU is an appropriate legal basis for the adoption of measures mandating larger health warnings on tobacco products and banning characterising flavours, and found that such measures were proportionate, while in *British American Tobacco* the UK High Court spoke out in favour of the proportionality of plain packaging measures, Mr Justice Green stating that 'the Secretary of State has adduced ample evidence to support the suitability and appropriateness' of plain packaging regulations, and that he 'rejects[s] the submission that there is a less intrusive but equally effective way of addressing the Government's health concerns'.[491] With these votes of confidence, it would appear that the EU legislature could pursue the adoption of plain packaging measures using the legal basis provided by Article 114 TFEU.

A further intervention that could be adopted using the powers provided by Article 114 TFEU might be the investigation of multinational corporations that are suspected of irresponsible practices that contravention EU regulations – for example the rules on alcohol marketing laid down by the Audiovisual Media Services Directive,[492] but which the First Application Report on the Directive suspected were regularly circumvented.[493] At present no truly effective way exists to investigate compliance with EU rules such as these. The ability to set up conduct scrutiny authorities under the authority of Article 114 TFEU has however been addressed by the CJEU in other fields. In the case of *UK v Parliament*,[494] the CJEU held that Article 114 TFEU would provide the legal basis for the enactment of a Regulation that gave powers to the European Securities and Markets Authority,

[488] In particular the tobacco industry has claimed that plain packaging would violate their right to intellectual property, on which see: J Griffiths, "On the back of a cigarette packet' – standardised packaging legislation and the tobacco industry's fundamental right to (intellectual) property' [2015] Intellectual Property Quarterly 323.
[489] Case C-547/14 *Philip Morris Brands and Others v Secretary of State for Health* [2016] ECLI:EU:C:2016:325.
[490] *British American Tobacco v Secretary of State for Health* [2016] EWHC 1169 (Admin).
[491] ibid, paras 35 and 36.
[492] Directive 2010/13/EU concerning the provision of audiovisual media services, OJ L 95, 15.4.2010, 1-24, Article 22.
[493] First Application Report on the Implementation of Directive 2010/13/EU, n 137 above, 7.
[494] Case C-270/12 *United Kingdom v European Parliament* [2014] ECLI:EU:C:2014:10.

which could be used to investigate natural and legal persons. In its judgement the Court held that 'nothing in the wording of Article 114 TFEU implies that the addressees of the measures adopted by the EU legislature on the basis of that provision can only be Member States'.[495] Thus, there is the possibility that in the addiction policy field, Article 114 could be used to create conduct scrutiny authorities that would be able to police compliance with EU public health standards.

III. Conclusion

Following the conclusions reached in the previous two chapters – that the addiction phenomenon may be explained by an addictiogenic environment model, and that the use of legal intervention in order to control factors of the addictiogenic environment that promote, encourage and facilitate the development of addictions is justified – this chapter has sought to demonstrate why the EU should contribute to efforts to control the addictiogenic environment, and that it has sufficient competence to be able to implement a range of useful and effective interventions that would target transnational factors of the addictiogenic environment, and would add value to the addiction policy activities of the Member States.

Although there are good arguments for keeping the EU out of sensitive areas of national policymaking, this chapter sought to show that control over the addictiogenic environment cannot be exerted by the Member States alone. Some factors of the addictiogenic environment transcend national borders, making it impossible for Member States to control them at their source. Any efforts that are made may even risk rebounding against the protection given by EU law to the free movement of goods and services. The purpose of this chapter was therefore to show that comprehensive and coherent control of the addictiogenic environment therefore requires the input of the EU, either in a coordinating or regulatory capacity.

This chapter furthermore explored the legal competences of the EU that will enable it to discharge its responsibility to contribute to the control of transnational factors of the addictiogenic environment. Not only does the EU have competence to take action in the public health and social fields to support the addiction policy activities of the Member States, it also, perhaps more importantly, has the power to harmonise conditions within the EU internal market so as to take the lead in addiction policy when common European standards are necessary to be able to exert control over transnational addictiogenic environment factors.

[495] ibid, para 107.

Thus, this chapter has sought to show that the EU has both the power and the mandate to contribute to the legal control of the addictiogenic environment. However, the actual contribution of the EU to supporting the addiction policies of its Member States has been poor to date. In fact, even the Member State policies that it should be lending support to have not been sufficiently focused and evidence-based, a situation that can be attributed in part to the EU's lack of intervention. Across all levels of policymaking, one can observe that the addictiogenic environment has not been approached coherently *as an addictiogenic environment*, and its factors are often not tackled in a coherent manner. At times, the environmental or social aspects of addiction causation are neglected altogether. Despite the wealth of evidence supporting the existence of an addictiogenic environment, and despite legal intervention being justified, strong legal interventions are not always likely to result from the way in which addiction is currently approached by national and EU policymakers. The next two chapters will therefore conduct an analysis of current approaches to addiction prevention, first focusing on the Member States, then on the EU, to assess the extent of these inadequacies.

CHAPTER FIVE – CURRENT MEMBER STATE APPROACHES TO ADDICTION POLICY

I. Introduction

Chapter Two argued that the development of addictions could be explained by an addictiogenic environment model, and raised the point that, in order to tackle Europe's currently strong addictiogenic environment, a coherent strategic approach is needed. This purpose of this chapter is to analyse how addiction issues have been addressed so far in the Member States, to evaluate whether evidence of the addictiogenic environment is being reflected in current national approaches to addiction policy design.

Since the EU has not yet engaged directly with the question of addiction, and has no named strategy on addiction, EU Member States have taken responsibility for addressing the issues raised by the addiction phenomenon. Ysa et al have produced a useful categorisation of the approaches taken, which shows that the way different countries deal with addiction issues is extremely varied, and fall along a broad spectrum from comprehensive approaches to sectoral approaches.[496] Comprehensive approaches to addiction generally place emphasis upon tackling addiction as a phenomenon, comprise a number of interventions designed to reduce the likelihood of addiction development, and cover multiple potential objects of addiction. Member States that approach addiction sectorally, on the other hand, address addiction as one of a range of issues within policies that focus on individual objects of addiction. Interventions within the policy may not be specifically aimed at reducing addiction per se, but will be aimed more generally at reducing harmful consumption of the object in question.

The work of Ysa et al shows that the Member States are diverse in how they deal with addiction issues for a number of reasons, including culture, political organisation, views of addiction, treatment services, and more. Clearly, there is no one-size-fits all way to govern addiction, and indeed no perfect solution to the problem.[497] If certain actions are particularly necessary in Member States in order to address particular factors of the addictiogenic environment, they should be taken. For example, in Greece 40 per cent of the adult population smoke, with half of adolescents in certain areas being regular smokers, making Greece the Member State with the highest rates of nicotine addiction by a large margin.[498] These rates of prevalence call for particularly strict national tobacco policy,[499] on a scale that might not be politically acceptable in other countries where smoking is less prevalent amongst the general population.

Despite the need for Member States to address addiction using interventions that work best in their national circumstances, it is also clear from earlier analysis that approaching addiction sectorally does not address the root causes of addiction, but rather treats addiction as one problem out of a

[496] T Ysa et al, *Governance of Addictions: European Public Policies* (Oxford University Press 2014). Their categorisation of addiction governance strategies is also discussed in L Stoll and P Anderson, 'Well-being as a framework for understanding addictive substances' in P Anderson et al (eds), *The Impact of Addictive Substances and Behaviours on Individual and Societal Well-being* (Oxford University Press 2015), 69.
[497] S MacGregor et al, The emergence and influence of the concept of governance in the European addiction field' in P Anderson et al (eds), *Reframing addictions: policies, processes and pressures* (The ALICE RAP Project 2014), 25.
[498] C Vardavas and A Kafatos, 'Smoking policy and prevalence in Greece: an overview' (2006) 17(2) European Journal of Public Health 211.
[499] ibid.

range of problems related to a single object, some of which may be completely unrelated to health or social protection. Sectoral approaches to addiction do not reflect the evidence on the common aetiologies of addiction, and by only tackling addiction within the context of individual objects of addiction are merely addressing the manifestations of addiction rather than dealing with the factors that are responsible for the development of *addictions*. Member States that employ sectoral approach to addiction, though they might have extremely well developed and effective policies on individual objects,[500] are unlikely to be making progress in tackling *the addictiogenic environment* in a coherent and comprehensive way.

The purpose of this chapter is to uncover best practice that is taking place in addiction policymaking in the Member States, and to investigate the extent to which the Member States are basing their addiction policies on evidence of the addictiogenic environment. The focus of this chapter will therefore be on Member States that have adopted comprehensive approaches to addiction prevention. For reasons of brevity, the chapter will restrict itself to conducting three case studies on the addiction policies of Germany, France and Spain. These three States all appear to have comprehensive national strategies on addiction. The analysis of these strategies will focus on the extent to which they have been designed in line with what evidence tells us of the existence of an underlying addiction phenomenon, the environmental determinants of addiction, and the existence of an addictiogenic environment.

II. Germany

On 15 February 2012, the German federal government adopted a National Strategy on Drug and Addiction Policy (herein referred to as the National Strategy).[501] This was adopted as a replacement for the previous Action Plan on Drugs and Addiction from 2003. According to the foreword of the Federal Drug Commissioner, it 'places Germany's drug and addiction policy on a modern footing'.[502] Analysis of this National Strategy reveals it to be highly holistic in its approach to the addiction phenomenon and committed to allocating responsibility for addiction policy across multiple levels. In these respects, it reflects the available evidence. However, the Strategy is compromised by an

[500] For example the Nordic states have traditionally pursued strict alcohol policies, see: J Cisneros Ornberg and H Olafsdottir, 'How to sell alcohol? Nordic alcohol monopolies in a changing epoch' (2008) 25(2) Nordic Studies on Alcohol and Drugs 129.

[501] *National Strategy on Drug and Addiction Policy* (Drug Commissioner of the Federal Government 2012), available online at http://www.emcdda.europa.eu/attachements.cfm/att_229612_EN_DE_2012_National%20strategy%20on%20drugs%20&%20addiction%20policy%20(EN%20version).pdf (last accessed 18 May 2016).

[502] ibid, 3.

overly narrow focus on the individual, and this draws the strategy away from strong legal interventions that would seek to reshape an individual's environment. Consequently, the Strategy cannot be said to wholly reflect evidence that environmental factors of addiction development are amongst the most influential and prevalent. Indeed, this National Strategy does not focus on the addictiogenic environment exactly, but on how individuals experience it, and due to this the National Strategy can only be seen as addressing part of the addiction problem.

The National Strategy is concerned specifically with the phenomenon of addiction and the development of addictive relationships, rather than with the manifestations of addiction, and thus it can be described as comprehensive. This much is clear from the Introduction to the Strategy, which recognises that 'addiction is linked to personal misfortune',[503] and that 'the development of an addiction has its roots in a complex network of previous individual experiences, certain living situations, interaction with other people, emotional disturbances, the influence of a significant figure and the availability of addictive substances'.[504] Clearly, the Strategy is based on the understanding that the causes of addiction 'go beyond just an addictive substance or behaviour'.[505] This has led the drafters to address addiction in a holistic manner. It is stated that 'the focus of our drug and addiction policy is not on addiction or on addictive substances',[506] but is instead on the problems that underlie the development of addiction, and this is evident from the substance of the strategy.

Consequently, the National Strategy sets out an 'integrative approach to addiction policy'[507] which takes 'both legal and illegal addictive substances into consideration'.[508] This is firm holistic thinking, and reflects evidence that addiction is caused by factors that run deeper than the simple overindulgence or dependence on a particular object of addiction. The first step to effectively controlling the factors of the addictiogenic environment is to recognise that the same factors can generate an addiction to many different objects of addiction, irrespective of whether those objects are legal or illegal to consume.[509]

[503] ibid, 6.
[504] ibid, 6.
[505] ibid, 6.
[506] ibid, 6.
[507] ibid, 8.
[508] ibid, 4.
[509] For a discussion on the false dichotomy between legal and illegal addictive objects, see: P Boland, 'British drugs policy: problematizing the distinction between legal and illegal drugs and the definition of the "drugs problem"' (2008) 55 Probation Journal 171.

Granted, despite the National Strategy professing to cover addictive substances and behaviours, the Strategy as a whole tends towards referring to 'substances', 'drugs' and 'consumption', indicating that the Strategy is more concerned with addictive objects that can be ingested, rather than addictive behaviours. However addictive behaviours are not ignored. Thus the second step to addressing the addiction phenomenon, rather than addiction manifestations, has been overcome – namely recognising that a behaviour can can be an 'object' of addictive consumption just as much as a substance. This reflects evidence that behaviours such as gambling can be extremely appealing to those suffering social dislocation as the object of an adaptive lifestyle,[510] and just as destructive as any substance.[511] In the section of the National Strategy that sets out its Goals, addiction to Internet usage and gambling are specifically recognised as 'new c[h]allenges [sic] in relation to addiction policy',[512] and addictive substances and behaviours are referred together on an equal footing on multiple occasions.[513] Pathological Gambling and Online Media Addiction are included as Sub-Areas of the National Strategy, on a equal footing with Sub-Areas on Alcohol, Tobacco, Prescription Drugs and Illegal Drugs.[514] By including so many different manifestations of addiction, the National Strategy increases the likelihood that interventions are designed with root causes of addiction in mind, and that these interventions will will be implemented for as many different manifestations as possible.

In addition to its focus on holisticism, the German National Strategy also makes significant effort to outline how responsibility for addiction prevention efforts should be shared between different levels of government, and between various types of stakeholders. The Introduction to the National Strategy specifically declares that 'the many different joint efforts and initiatives to prevent addiction and to reduce the harmful consumption of and dependency on addictive substances and behaviours are thus to be coordinated with each other on the national and international level'.[515] In particular, the National Strategy recognises that:

> 'in our federal system, numerous people and organisations are active in the area of addiction prevention and addiction services. This spectrum includes municipal governments, the Lander, the federal government … providers of services on various levels also play a role

[510] R Duclos et al, 'Show me the honey! Effects of social exclusion on financial risk-taking' (2012) 40 Journal of Consumer Research 122.
[511] B Morasco et al, 'Health problems and medical utilization associated with gambling disorders: results from the national epidemiologic survey on alcohol and related conditions' (2006) 68(6) Psychosomatic Medicine 976.
[512] *National Strategy on Drug and Addiction Policy*, n 501 above 10.
[513] ibid, 12, 14, 16.
[514] ibid, 41-46.
[515] ibid, 6.

> …the diversity of the many parties involves requires comprehensive coordination and integration in to a single network'.[516]

The fact that the National Strategy is organised in a multilevel way reflects evidence that no one actor has the solution for complex policy problems such as that presented by the addictiogenic environment, and that therefore responsibility should be dispersed among all actors who are able to contribute to solving the problem.[517]

A good example of effective allocation of responsibility can be found in one of the declared Cornerstones of the National Strategy – 'Reaching More People in a Local Context – Expanding Addiction Prevention in the Workplace'[518] – which recognises that employers, insurers, and related stakeholders can utilise workplaces, a local environment which most people experience on a regular basis, to conduct effective local level addiction prevention work. This reflects a large body of evidence that suggests that problems at work can be a significant contributor to the build up of stress and negative affect, precursors to social dislocation.[519] The National Strategy also attempts to ensure that various local stakeholders work together in pursuit of common objectives: 'in order to achieve better integration, policy must focus on the interfaces between the systems of providing aid, so that no addict gets lost in it … Networks and integrated care approaches… are one way of effectively managing interfaces'.[520]

The importance of integrating international action is also made clear in the National Strategy. A whole section of the National Strategy called 'International and European Drug and Addiction Policy' is dedicated to explaining how 'drugs and addiction are global problems that require joint activities by all parties in the international community'[521] and how 'Germany cannot meet the challenge of the drug and addiction problem solely though national policies'.[522] This is a hugely important step in building an effective approach to addiction, one which recognises and reflects crucial evidence that some causal factors for addiction are transnational in nature, and can only be effectively controlled through joint state action at international level. The German National Strategy acknowledges that

[516] ibid, 6.
[517] See: M Clarke and J Stewart, 'Handling the Wicked Issues' in J Reynolds et al (eds) *The Managing Care Reader* (London: Routledge 2003), 274.
[518] *National Strategy on Drug and Addiction Policy*, n 501 above, 13.
[519] Wilkinson and Marmot, n 136 above, 18.
[520] *National Strategy on Drug and Addiction Policy*, n 501 above,14.
[521] ibid, 58.
[522] ibid, 58.

action by the German Federal Government will not be sufficient to reduce preventable addiction in Germany – the contribution of international actors must also be integrated into their plans.

Thus, there are several aspects of the German National Strategy that are solidly grounded in the evidence available on how addictions are developed – interventions are targeted at the root causes of addiction, and responsibility for interventions is given to actors that are best placed to carry them out. However, one important aspect of the German approach has not been designed in line with available evidence. The National Strategy focusses on 'individuals with their specific problems',[523] and by this very fact places insufficient emphasis upon the evidence that environmental factors drive the development of addictions to a far greater extent than factors related to individuals. Consequently, parts of the National Strategy may not prompt interventions of the highest effectiveness. There are several reasons for this.

First, focussing on individuals and their problems implies that individuals themselves are the problem, and creates contradictions in the overall approach. Although addiction is 'not a matter of personal failure'[524] according to the National Strategy, its goal is nevertheless to 'promote personal responsibility'.[525] The real problem, however, is that making addiction a matter of personal responsibility and trying to ensure that individuals are 'approaching the use of pleasurable and addictive substances responsibly … and finding the right balance',[526] belies the well-evidenced fact that personal responsibility is only a small part of the development of addictions.[527] More important in the development of addictions are deep social inequalities, corporate behaviour and weak legislation, over which individuals have no control. The focus on individuals and how they interact with the addictiogenic environment therefore sidelines a range of more important factors connected to the constitution of the addictiogenic environment itself, and consequently the policy tools necessary to tackle them. For example, of the eight interventions detailed in the Alcohol Sub Area, only one could be described as combatting a factor that contributes to creating the addictiogenic environment – alcohol advertising.[528] There is no mention of other effective methods of weakening the addictiogenic environment, such as taxation or outlet density regulations. The other seven interventions relate in some way to how individuals experience and attempt to recover from

[523] ibid, 6.
[524] ibid, 8.
[525] ibid, 8.
[526] ibid, 2.
[527] For more discussion, and an analysis of how policymaking might incorporate both personal responsibility and environmental perspectives on addiction prevention, see: K Brownell et al, 'Personal responsibility and obesity: a constructive approach to a controversial issue' (2010) 29(3) Health Affairs 379.
[528] *National Strategy on Drug and Addiction Policy*, n 501 above 22.

addiction, with many of them relying on information and education provision. This approach forces individuals to take on responsibility for problems that in vast part are not of their making. This is not only an unfair but an inefficient way of tackling addiction.

Second, a focus on the individual leads to a strategic approach that is highly medicalised in nature. Two of the four Levels of the National Strategy are Counselling and Treatment and Harm Reduction, with the other two dedicated to Prevention and Repression of illegal drug supply. This medical focus is even confirmed in the Introduction – 'this national strategy is intended as a health policy guideline'.[529] Based on the fact that evidence suggests that the factors contributing to addiction causation are multifactoral and varied, policy should go beyond merely health interventions in order to be effective, embracing a wide range of policy fields.[530] The factors comprising the addictiogenic environment stem from the arrangement of economic policy, to social conditions, to business freedoms and beyond, and thus addiction policy cannot simply be an extension of health policy. Unfortunately the German National Strategy, despite understanding that addiction is a phenomenon with root causes, understands these root causes according to the disease model. [531] The result is a health policy driven, medicalised approach to addiction, which ignores relevant policy fields on account of the overriding concern to help individuals avoid and recover from the disease of addiction.

Finally, a focus on the individual naturally also leads to contradiction through the natural prioritisation of some individuals over others. The National Strategy claims that addiction interventions should 'be better targeted and focus more strongly on high-risk groups' and that 'for every addictive substance or behaviour, the groups at greatest risk must be identified and addressed directly'.[532] However, this contradicts evidence that suggests that vulnerability is not a characteristic inherent to certain easily identifiable groups of people, but is a dynamic concept that is created by the environment in which an individual is placed.[533] Any number of people could be or become vulnerable to addiction and thus be in need of protection, especially in light of the extensive nature of the addictiogenic environment. Consequently, despite identifying categories of high-risk

[529] ibid, 7.
[530] For an analysis of why a whole of government approach to public health problems is required, see: P Puska and T Stahl, 'Health in all policies – the Finnish initiative: background, principles, and current issues' (2010) 31 Annual Review of Public Health 315.
[531] *National Strategy on Drug and Addiction Policy*, n 501 above, 8.
[532] ibid, 12.
[533] L Waddington, 'Vulnerable and confused: the protection of "vulnerable consumers" under EU law' (2013) 38(6) European Law Review 757.

individuals that cover quite a wide range of people – 'people who have had negative experiences'[534] and 'stress situations'[535] for example – such an approach could not hope to provide individually tailored treatment[536] (as the National Strategy claims) to all those who may be likely to develop an addiction.

In summary, the above analysis of the German National Strategy on Drug and Addiction Policy reflects a lot of the evidence available on the operation of the addictiogenic environment, particularly regarding the need to address the underlying root causes of addiction and the need to allocate policy responsibility to those best suited to taking action. However, the fact that addiction is primarily developed in response to environmental factors, and that deep structural factors will promote the conditions in which addiction is likely to be developed, is not reflected particularly well. Thus the German approach to addiction is compromised in an important way, making it unlikely that it will be fully effective in achieving its goal of helping individuals to overcome addictions.

III. France

The French Government established the Interministerial Mission for the Fight against Drugs and Drug Addiction (herein referred to as 'the Mission') in 1982, with the purpose of 'organising and coordinating the State's activities regarding the fight against drugs and drug addiction'.[537] On 17 October 2012 the Prime Minister tasked the Mission with constructing a renewed strategy to combat drugs and addiction,[538] and on 19 September 2013 the Government Plan for Combating Drugs and Addictive Behaviours 2013-1017 (herein referred to as the 'Government Plan') was launched. In the Preface to the Strategy written by the French Prime Minister, this newest Government Plan responds to the need for 'society at large, as well as the authorities as a whole, to take action'[539] to meet the challenges of addiction, and in doing so will 'mobilise all of the ministers concerned, that is to say effectively the government as a whole, in the fight against drugs and

[534] *National Strategy on Drug and Addiction Policy*, n 501 above, 13.
[535] ibid, 13.
[536] ibid 17.
[537] See: http://www.drogues.gouv.fr/page-simple/mildeca-interministerial-mission-combating-drugs-and-addictive-behaviours (last accessed 19 May 2016).
[538] See Mission Statement of 17 October 2012 in the Government Plan for Combating Drugs and Addictive Behaviours 2013-2017 (Mission interministérielle de lutte contre la drogue et la toxicomanie 2013) available online at http://www.emcdda.europa.eu/attachements.cfm/att_229608_EN_FR_plan_gouvernemental_drogues_2013-2017%20(EN%20Version).pdf (last accessed 19 May 2016), 9.
[539] Government Plan for Combating Drugs and Addictive Behaviours 2013-2017 (Mission interministérielle de lutte contre la drogue et la toxicomanie 2013) available online at http://www.emcdda.europa.eu/attachements.cfm/att_229608_EN_FR_plan_gouvernemental_drogues_2013-2017%20(EN%20Version).pdf (last accessed 19 May 2016), 3.

addiction'.[540] Analysis of this French Government Plan shows that it is very different to the German National Strategy. It is characterised by an effort to tackle addiction across multiple policy areas, displaying greater understanding of the role of the addictiogenic *environment* in the development of addiction. However, it does not adequately recognise the complexity of the addictiogenic environment problems, and the consequent need to allocate policy responsibility amongst multiple actors.

Unlike the German National Strategy, this French Government Plan starts from a desire to employ a whole of government approach to addiction policy. The very fact that the Plan is coordinated by a body called the *Interministerial* Mission is evidence of this intent. Within the Mission Statement of 2012, the response to addiction is described as a 'transverse policy to which each Ministry needs to contribute in its own field of competence, to match the efforts required by the fields of public initiative for which is is responsible as a whole'.[541] This is a positive decision to mainstream addiction policy into all relevant policy fields. Mainstreaming is a policy approach whereby all government departments are requested not only to contribute to addiction policy within their own policy field, but to ensure that their contribution to addiction policy is coherent with the policies adopted generally within their policy field. Thus, fiscal policymakers for example are requested to consider how fiscal policy can contribute to addiction prevention, and ensure that fiscal policy generally does not undermine the objectives of addiction prevention. Mainstreaming is an approach to policymaking that has been recognised to be essential to the successful resolution of problems with public health and social justice dimensions,[542] such as addiction prevention, and it is therefore a good sign to see a mainstreaming approach adopted by the French Government Plan.

Under the mainstreaming approach, numerous suggestions are made for intervention that are related to policy fields other than public health. These are often linked back to root causes of the addiction phenomenon to demonstrate their relevance. For example, price rises are encouraged for tobacco.[543] Second-chance schooling is encouraged for the 'social and professional integration of disadvantaged young people'.[544] Furthermore, the plan makes extensive provision for multidisciplinary research into addiction 'in order to gain a more accurate understanding of the

[540] ibid, 3.
[541] ibid, 9.
[542] P Hawe, 'The social determinants of health: how can a radical agenda be mainstreamed?' (2009) 100(4) Canadian Journal of Public Health 291.
[543] Government Plan, n 539 above 25.
[544] ibid, 24.

factors of vulnerability to addictive behaviours'.[545] Finally, the Plan acknowledges that 'legislative, regulatory and administrative measures contribute to ensuring an environment conducive to the prevention of addiction by providing a framework for the social and economic context within which drug use takes place'.[546] This all demonstrates that the focus of the Government Plan is upon tackling the factors making up the addictiogenic *environment*, and not simply on addressing the most obvious symptoms of addiction.

The Government Plan even attempts to mainstream consideration of the addictiogenic environment into addiction treatment. In a section entitled 'Promoting the Social and Occupational Dimension of Overall Healthcare, the Plan states that:

> 'therapeutic strategies aimed at patients presenting addictions need to include psychological and social follow-up work. Long-term treatment of addictions, combined with social and occupational rehabilitation work, including housing, are key elements of the success of such healthcare … To this end it will be appropriate to build upon the tools recommended in the long-term plan against poverty and for social inclusion. The overall objective is to succeed in ensuring stable places of residence'.[547]

By linking addiction treatment with an aspect of addiction prevention, the Government Plan has managed to integrate treatment and prevention, demonstrating that both can contribute in a coherent manner to tackling the addictiogenic environment.

The French Government Plan is also designed in a way that reflects the evidence on root causes of addiction. The 2012 Mission letter lays the foundation for a holistic approach by declaring that:

> 'a consistent and coordinated approach to the prevention of addictive behaviours requires the elaboration of an active policy including tobacco, alcohol, psychotropic prescription drugs and narcotics. The phenomena of "poly-drug use", the practice of doping and non-substance based addictions (for example gambling addiction) need to be taken into account'.[548]

[545] ibid, 73.
[546] ibid, 22.
[547] ibid, 42.
[548] ibid, 9.

This is followed up in the Introduction to the Plan, which acknowledges that 'reality calls for a rethinking of the focus of our policy for combatting drugs and addictive behaviours'.[549] Throughout the Plan, reference is made to 'addictive behaviours' to describe the result of an addictive relationship being formed, and specific references are made to gambling and other forms of behavioural addiction.[550] This, like the German approach, reflects the body of evidence that suggests that the process of addiction development has common causes, and can manifest in an addiction to a number of different objects.

In particular, a priority of the Government Plan, according to the pillar on 'Basing Policies for Combatting Drugs and Addictive Behaviours upon Research and Training', is understanding addiction development in relation to both substances and behaviour. In particular the Plan recognises, that there is a need to 'improve knowledge of addictive behaviours as "social practices"',[551] and specifically when it comes to behavioural addictions, that 'addictive behaviours involving gambling and video games constitute an emerging area of research'[552] which requires support. It is therefore evident that the Government Plan takes the need to develop the evidence base on behavioural addictions seriously.

Despite this French Government Plan strongly reflecting the available evidence on the holistic nature of addiction development, and the need to address the addictiogenic environment through the input of all relevant policy fields, it is weak in reflecting the evidence that suggests responsibility for addressing addiction issues should be shared across multiple levels. The multilevel allocation of policy responsibility is not emphasised strongly in the strategic outline of the Government Plan. In fact, where multiple levels of government are mentioned, it is in terms of the central government providing support to regional levels of government, rather than the sharing of responsibility between national and regional levels of government.[553] The priorities of the Plan are to be 'implemented with the support of the network of heads of drug addiction projects, placed in close relation with the prefects, at the departmental and regional levels. In order to ensure consistence of public initiative it is important to make sure that the regional health agencies are involved in the reflection and work undertaken by the heads of project'.[554] Consequently, the role of the sub-national level is seemingly to simply act as a tool of the national level strategy, rather than as a

[549] ibid, 13.
[550] For example, see: ibid, 32, 43.
[551] ibid, 74.
[552] ibid, 75.
[553] 'These directions are to be implemented with the support of the network of heads of drug addiction projects, placed in close relation with the prefects, at the departmental and regional levels': ibid, 10.
[554] ibid, 10.

partner to the national level. Furthermore, 'the MILDT regional and departmental heads of project organise the territorial implementation of public policy for combating drugs and addictive behaviours, in association with ARS and local education authorities, while respecting these different bodies respective areas of competence'.[555] Thus, regional offshoots of the central addiction governance authority are responsible for implementing centrally designed addiction policy at the regional level, with local authorities only 'associated' with this implementation. This insistence on a centralised response does not capture the advantages of sharing policy responsibility among governing levels,[556] and indeed the available evidence which suggests that some factors of the addictiogenic environment are generated at the local level and must therefore be dealt with by local policymakers who are able to implement a tailored solution.[557]

The way in which the supranational level is integrated into the Plan also demonstrates a lack of understanding of the purpose of governing on multiple levels. Instead of recognising the need for European and international solutions to be factored in to the national level strategy, the French Government Plan sees the existence of the supranational level as an opportunity to promote French ideas for addiction policy. The Government Plan states that 'at the international level, the MILDT will contribute … to the elaboration of the French position in international and European bodies ... in particular, the MILDT will promote France's overall integrated approach'.[558] While it is true that the international level should act as a forum for sharing ideas about public health and social problems, and may facilitate the diffusion of effective policy between countries,[559] addressing the addictiogenic environment requires that national governments must *also* work together to produce distinct *supranational* policies that should then be factored into national approaches. The French Government Plan does not appear to recognise this.

A small section of the Government Plan is dedicated to Reinforcing Coordination at National and International Levels,[560] however the emphasis of this section is very much on managing subnational implementation of addiction policy, rather than facilitating the contribution of subnational level policymakers. Similarly, the supranational level is seen as a tool of national strategy, rather than a

[555] ibid, 84.
[556] For example, Hooghe and Marks identify increased flexibility in responding to policy problems as one of the advantages of dispersion of governance responsibility: L Hooght and G Marks, *Unraveling the Central State, But How? Types of Mulei-Level Governance* (Vienna: Institute For Advanced Studies 2003), 5.
[557] For an analysis of this point, see: M Ashe et al, 'Local venues for change: legal strategies for healthy environments' (2007) 35(1) The Journal of Law, Medicine and Ethics 138.
[558] Government Plan, n 539 above 10.
[559] See the discussion in: M Whitehead, 'Diffusion of ideas on social inequalities in health: a European perspective' (1998) 76(3) The Milbank Quarterly 469.
[560] Government Plan, n 539 above, 81.

fundamental level of the governance approach within a nation, to which some responsibility should be given to facilitate pursuit of the priorities identified by the national government. According to the Plan 'the European Union constitutes a major channel and level for the policy conducted at the national level'.[561] Furthermore, holding the presidencies of supranational bodies engaged with work related to addiction apparently 'constitute[s] a favourable period for promoting our policy'.[562]

In summary, the French response to addiction shows a good awareness of how environmental factors combine to influence the likelihood of addiction development, and there are a number of evidence based interventions that target important aspects of the addictiogenic environment. However, the strategy is short-sighted when it comes to allocating responsibility for these interventions. The complex nature of the addictiogenic environment cannot be efficiently or effectively addressed by relying upon action dictated solely by national governments, yet the French Government Plan seems to overlook the need for a cooperative approach that allocates responsibility for design, and not just implementation, to the most suitable level of authority.

IV. Spain

Spain's current approach to addiction governance is contained within the National Drug Strategy 2009-2016 (hereafter referred to as the Strategy),[563] a document adopted in early 2009, together with a complementary Action Plan adopted in October 2009. The current Strategy is an evolution upon previous strategies, which according to the current version date back over 25 years, and which 'represents the huge institutional, social and scientific agreement to guarantee an homogenous, fair and quality response, in the whole national territory for the next eight years, approaching the drug problem'.[564] It is 'the result of the ideas and contribution of experts, Administrations as well as the 25 years of experience in the National Plan on Drugs'.[565] The Strategy makes a bold claim to be:

> 'a strategy with a humanitarian perspective emphasising the respect to the rights of the affected individuals; that also promotes the approximation to the population at risk it protects the public health, alleviates the suffering of the affected individual, offers

[561] ibid, 87.
[562] ibid, 88.
[563] *National Drug Strategy 2009-2016* (Ministerio de Sanidad y Politica Social 2009) available online at http://www.pnsd.msssi.gob.es/pnsd/estrategiaNacional/docs/StrategyPNSD2009-2016.pdf (last accessed 29 September 2016).
[564] ibid, 5.
[565] ibid, 5.

information and the required skills of responsible decision making and reduces damages produced by drug abuse in the abuser as well as in the entire society'.[566]

These are bold claims indeed – and analysis shows that the Spanish Strategy appears to succeed in capturing the complexity of the addictiogenic environment, combining action across multiple policy fields with the allocation of responsibility over multiple levels. Like the German and French approaches though, the Spanish Strategy has one major weakness, which is that it fails to reflect the evidence that suggests that all addictions should be addresses simultaneously as manifestations of the same set of causal factors.

The Strategy is impressive in its breadth. It clearly attempts to embrace an all-of-government approach, which indicates that the evidence supporting a mainstreamed approach to tackling addiction has been properly considered. The Strategy is claimed to 'represent … agreement on the priorities among all agents who participate in the National Plan on Drugs'[567] and describes a complex networked process in which several different bodies and organisations contribute to controlling addiction. This spirit of cooperation is reflected in the Guiding Principles and General Objectives of the Strategy, which anchors the Strategy in 'the most widely accepted and supported approach – and that for which there is most evidence of success … to act through[568] a combination of measures which simultaneously intervene in the spheres of exposure and access to psychoactive substances'.[569] Thus, the need for an evidence based approach to addiction policy is specifically recognised in the Strategy.

The Strategy actively encourages action across the policy spectrum, where there is sufficient evidence to justify such action.[570] The focus on constructing 'a multifactor, inter-sectorial and multi-disciplinary focus and approach, [which] aspires to an optimisation of efforts and resources by means of coordination and cooperation between the different agents'[571] has even led the drafters of the Strategy to explore 'other health strategies' and 'other sectorial plans' so that 'their impact and inter-relationships were considered'.[572] Transdisciplinarity and translational collaboration between

[566] ibid, 5.
[567] ibid, 7.
[568] ibid, 45.
[569] ibid, 39.
[570] The Strategy states at page 39 that: 'consideration of scientific evidence' is one of the guiding principles of the Strategy, and that 'interventions will be prioritised and defined in accordance to the nature of the evidence'.
[571] National Drug Strategy, n 563 above 40.
[572] ibid, 21.

multiple fields is recognised to be an important aspect of effective public health policy making.[573] The Strategy not only encourages policy learning, but also attempts to define how different addiction policies might be linked together in a coherent manner. There is a whole section dedicated to coordination, which starts by acknowledging that addiction is caused by 'a wide range of determinants and dimensions'[574] and that this calls for 'vital collaboration of all agents with responsibility in the sectors of activity concerned'.[575] The rationale for this is even explained – 'coordination facilities both better planning of interventions executed by the agents involved as well as a more rational and efficient use of all resources'.[576] Thus, the Spanish approach has clearly been designed with evidence on policy coherency in mind, in order to avoid a simple collection of individual and possibly contradictory policies.[577]

The Spanish Strategy not only does well in reflecting the evidence on the complexity of policy problems such as addiction, it also clearly reflects the need for a multilevel approach to addiction. The need to allocate policy responsibility to the most appropriate level of government, or the most appropriate set of stakeholders is noted in the Introduction to the Strategy, which acknowledges that 'coordination and collaboration between the national civil services … and the regional administrations plays a fundamental role at the heart of the framework'[578] and that:

> 'at the design phase, the Strategy has taken into account the main national and international planning documents currently available. On the one hand, the plans on drugs and Strategies of the Spanish autonomous communities and cities, and on the other, those of a range [of] comparable countries, with very particular reference to the strategies and action plans approved by the European Union. Local government has also been involved, through its representative body'.[579]

As can be seen, unlike the French Government Plan, the Spanish Strategy views the subnational and supranational levels of government as building blocks of the national strategy, rather than as tools of it. The Strategy acknowledges that the competence of different administrations over different

[573] S Leischow et al, 'Systems thinking to improve the public's health' (2008) 35(s2) American Journal of Preventive Medicine S196, S201.
[574] National Drug Strategy, n 563 above, 45.
[575] ibid, 45.
[576] ibid, 45.
[577] For an illustration of why policy coherence is essential in complex policy domains, see: P May et al, 'Policy coherence and policy domains' (2006) 34(3) Policy Studies Journal 381.
[578] National Drug Strategy, n 563 above, 20.
[579] ibid, 21.

aspects of policy must be respected in constructing an effective approach to addiction.[580] This translates, for example into the following approach to demand and supply reduction of psychoactive substances:

> 'in the field of demand reduction, the greatest involvement and commitment basically corresponds to the administrations with responsibility and competences in health, social and educational areas. Actions in this field must necessarily be of a transversal character … therefore they will have to involve the public administrations in different territorial spheres with jurisdiction in the field itself … the areas of supply reduction is a special jurisdiction of the national police force'.[581]

Division of responsibility is more likely to result in specific problems being dealt with by those with the greatest knowledge to achieve the best result,[582] and therefore the Spanish Strategy should be seen, in this respect, as successful in implementing an evidence based response to addiction.

However, in other respects, the Spanish Strategy is distinctly less evidence based. The Strategy recognises that 'obviously there is addictive behaviour which does not involve the use of psychoactive substances, and this behaviour can product serious undesirable effectors on people's health and quality of life'.[583] However, as its name suggests, it explicitly excludes these behavioural addictions from its scope – 'nevertheless, whilst recognizing the steady growth of these addictions in today's society, attention to them and treatment of this type of addiction is not included within the framework of this Strategy'.[584] This is disappointing given the Strategy's apparent commitment to being founded upon 'strategic, holistic approaches',[585] and given the Strategy's commitment to basing action on scientific evidence. There is a clear rejection of evidence that suggests that addiction is a phenomenon, and that all addictions share essentially the same root causes.

Although the word 'holistic' is used several times throughout the Strategy,[586] this refers primarily to the fact that coordination between various actors and policy areas is necessary, rather than to the

[580] ibid, 45.
[581] ibid, 45.
[582] For an analysis of how the multilevel division of responsibility has enabled progress on tobacco control, see: B Asare et al, 'Federalism and multilevel governance in tobacco policy: the European Union, the United Kingdom, and devolved UK institutions' (2009) 29(1) Journal of Public Policy 79.
[583] National Drug Strategy, n 563 above, 22.
[584] ibid, 45.
[585] ibid, 17.
[586] ibid, 5, 8, 9, 17.

fact that root causes of addiction should be addressed. A distinction should be drawn between two concepts – holisticism, meaning the need to target root causes rather than manifestations, and horizontality, meaning the need to employ a broad range of policy fields and policy actors across the policymaking spectrum.

While true holisticism is rejected by the Spanish Strategy, there is nonetheless an attempt to go beyond manifestations of addiction, even though a clear distinction between holisticism and horizontality is not drawn by the Strategy. At the beginning of the section on Coordination, the Strategy states that 'the phenomenon of drugs and drug addictions is due to a wide range of determinants and dimensions. In order to facilitate the development of a consistent policy in relation to the phenomenon and its derived manifestations, it is … necessary to consider the different perspectives'.[587] Furthermore, when introducing its Guiding Principles, the Strategy notes that 'many of the actions are specific to a limited number of the spheres, but there are also many which have common objectives. Logically, efforts should focus on the earliest identified stages or risk factors and should therefore especially target the area of protection against the most global factors of risk caused by exposure to drugs'.[588] Recognition of evidence of an addiction phenomenon is therefore made in the Strategy, even if behavioural addictions are excluded from its scope.

Overall, the Spanish Strategy is probably the most complete of the three comprehensive approaches to addiction analysed in this chapter, and therefore probably likely to stand the best chance of sufficiently weakening the addictiogenic environment to the point where noticeable reductions in addiction prevalence may be observed. However, the Spanish Strategy, like the German and French efforts, is still flawed in an important way, because it tries yet ultimately fails to implement the kind of holistic approach that is required in order to make serious inroads into weakening the addictiogenic environment.

V. Conclusion

A number of lessons can be drawn from the three case studies conducted in this chapter. First, no Member State will address addiction in the same way, and nor should it have to. There is an infinite number of potential combinations of policies and organisational structures that Member States could adopt, and this is a good thing – there are an infinite number of subtle variations of the main

[587] ibid, 45.
[588] ibid, 39.

identifiable factors of the addictiogenic environment. Member States should therefore be free to address national idiosyncrasies in whatever way they think most appropriate, and be able to design interventions that control their particular addictiogenic environments in whatever manner best reflects the ways in which their populations experience it.

Second, it is possible to identify three key principles of addiction policymaking from analysis of the three Member State approaches above: the targeting of the root causes of addiction rather than specific manifestations, which we could call *holisticism*; the contribution of multiple fields of policymaking and multiple stakeholders to policymaking, which we could call *horizontality*; and the division of policymaking responsibility across multiple levels of public authority, which we could call *multilevel governance*. These three principles, when implemented well, could constitute a framework of best practice for responding to the addictiogenic environment. We could, and should, learn much from how Member States that embrace these principles in their addiction policies operationalise them. However, as was clear from the analysis conducted above, none of the Member State approaches considered above, despite claiming to be comprehensive, were able to effectively operationalise all three principles.

Thus, neither the German, French, nor Spanish approaches to addiction policymaking have utilising the available evidence to the best extent. This appears to be reflected in statistics on the prevalence of addiction in these countries, which suggest that the strategies analysed above are not having the desired impact. For example between 2011 and 2015, alcohol use, soft drug use and smoking all rose in France.[589] The Spanish Strategy's failure to integrate behavioural addictions is reflected in the fact that an estimated 5% of Spanish high school students display signs of internet addiction.[590] It might therefore be concluded that in order to ensure that the most effective approach to addiction policymaking is being taken, national policymakers should ensure that their strategies reflect all three principles identified above – holisticism, horizontality and multilevel governance.

Three Member States with an apparently good grasp of what addiction is, and how it might be approached, have all failed to fulfill the potential that a comprehensive approach to addiction offers for effective control of the addictiogenic environment. Why might this be? The central contention of

[589] O Gee, 'Alarming rise in drug use among French teens' (*thelocal.fr*, 21 April 2015), available online at https://www.thelocal.fr/20150421/alarming-rise-in-drug-use-among-young-french-women (last accessed 25 September 2016).
[590] O Lopez-Fernandez et al, 'The problematic internet entertainment use scale for adoplescents: prevalence of problem internet use in Spanish High School students' (2013) 16(2) Cyberpsychology, Behaviour, and Social Networking 108.

this thesis is that the EU could and should make a greater contribution to efforts to reduce the prevalence of preventable addiction in Europe. One reason for why the Member States are not performing as effectively as they could in controlling the factors of the addictiogenic environment may be that the EU has not been contributing effectively to addiction policymaking at the supranational level. In order to be effective, multilevel governance requires that all levels of authority to which responsibility is allocated must actually discharge that responsibility. Furthermore, in the case of difficult policy issues, coordination between Member States allows the sharing of best practice that could lead to some Member States being able to adopt policies that are superior to the approach they would previously have taken.

The next chapter will develop the argument that the ways in which the EU has contributed to addiction policy to date have not only been sparse (save some contributions made in the tobacco field) in comparison to the responsibilities that it could and should take on, but have not been entirely conducive to allowing the Member States to discharge their own responsibilities in addiction policymaking.

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CHAPTER SIX – CURRENT EU APPROACHES TO ADDICTION POLICY

I. Introduction

Detailed case studies of three Member State strategies that claimed to be comprehensive showed that three principles of best practice in addiction policy could be identified – holisticism, horizontality and multilevel governance – however that none of the Member States studied have been able to combine them all into their approaches to addiction policymaking. It was hypothesized that this may be due, in part, to the EU's lack of engagement with addiction issues, which may be causing some factors of the addictiogenic environment to be dealt with at the wrong level or not at all, and may be preventing the Member States from learning from each other when policy learning is appropriate. This chapter therefore seeks to uncover whether the EU has been doing all it can to discharge the responsibilities that have been and should be allocated to it for the control of the addictiogenic environment, and to ensure that Member States are able to discharge their own addiction policy responsibilities free from interference.

The EU does not have a specific, codified strategy on addiction, and no specific overarching policy approach. This is consistent with the relationship between the Member States and the EU that has been established in the public health and social protection fields. Consistent with the nature of its competences in these fields, and the existence of transnational elements of the addictiogenic environment, the EU does however have responsibilities to contribute to the control of the addictiogenic environment, with a view to supporting the Member States as they work towards the ultimate objective of stepping up the fight against NCDs. In order to assess how well the EU has fulfilled these responsibilities, this chapter will focus on assessing what the EU has accomplished in individual policy fields that focus on specific objects of addiction. Three such policy fields will be considered here – tobacco, alcoholic beverages and gambling services.

Aside from the fact that it is the only object of addiction that will eventually kill one in two regular users,[591] the EU's tobacco control efforts have been chosen as a focus field because most EU harmonising measures relevant to the prevention of addiction have been adopted on tobacco. Analysis of these measures, in particular the Tobacco Advertising Directive[592] and the Tobacco Products Directive,[593] will allow an examination of the extent to which the EU has used its harmonisation competence to address cross-border addiction issues, as well as the extent to which it has fulfilled its obligations to mainstream public health concerns into internal market policy.

The EU's policy on alcoholic beverages has been chosen as a focus field because it is the only addictive object for which the EU has at some point adopted a codified strategy under its public health competence - the 2006 EU Alcohol Strategy. Examining alcohol policy will permit an assessment of how the EU has used its complementary competence in relation to addiction issues. Furthermore, EU alcohol policy has been substantially conditioned by the subsidiarity principle – therefore examining the EU's approach to alcoholic beverages will enable an assessment of the EU's attitudes towards multilevel policymaking.

[591] Hastings, n 116 above, e5124.
[592] Directive 2003/33/EC of the European Parliament and of the Council of 26 May 2003 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products OJ L 152, 20.6.2003, p 16-19.
[593] Directive 2014/40/EU of the European Parliament and of the Council of 3 April 2014 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC OJ L 127, 29.4.2014, p1-38.

Gambling services have been chosen primarily because gambling services are addictive objects that are routinely provided by Member States, and as such it will allow a comparison between how the EU has approached addictive objects that are exclusively produced and marketed by the private sector and how it has (and indeed can) approach addictive objects that are produced and marketed by both private and public authorities. Since gambling services are also behavioural objects of addiction, examining the extent to which the EU has engaged with gambling services will facilitate an assessment of the EU's commitment to encouraging holisticism in addiction policy, in addition to permitting further exploration of how the EU has interpreted the requirements of multilevel policymaking.

By contrast, psychotropic drugs have been excluded as a focus field of this chapter. Tobacco, alcoholic beverages and gambling services are part of the global free market. Psychotropic drugs, however, are not. Although common objects of addiction, consumption of which can lead to serious health harms,[594] psychotropic drugs are subject to a global prohibition regime.[595] Three United Nations Conventions, adopted in 1961,[596] 1971[597] and 1988[598] oblige UN member states to create a number of criminal offences relating to natural and synthetic narcotic substances, including their possession, acquisition, and distribution.[599] Under this regime, states are required to maintain some form of formal drug prohibition,[600] and consequently policy experimentation is mostly foreclosed.[601] Amendment of one or more of the three UN Treaties, or their complete renunciation, would be required in order to permit such experimentation, yet such a development is unlikely.[602] Drug

[594] See for example: D Nutt et al, 'Drug harms in the UK: a multi criteria decision analysis' (2010) 376 Lancet 1558.
[595] H Levine, 'Global drug prohibition: its uses and crises' (2003) 14 International Journal of Drug Policy 145, 145.
[596] Single Convention on Narcotic Drugs (adopted 30 March 1961, entered into force 3 December 1964) 520 UNTS 151 (Single Convention).
[597] Convention on psychotropic substances (adopted 21 February 1971, entered into force 16 August 1976) 1019 UNTS 175.
[598] United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (20 December 1988, entered into force 11 November 1990) 1582, UNTS 95 (Convention against Illicit Trafficking).
[599] EMCSSA Thematic Papers - Illicit Drug Use in the EU: Legislative Approaches (European Monitoring Centre for Drugs and Drug Addiction 2005, available online at http://www.emcdda.europa.eu/attachements.cfm/att_10080_EN_EMCDDATP_01.pdf#page5 (last accessed 23 June 2016), 6.
[600] Levine, n 595 above, 146.
[601] R Room and P Reuter, 'How well do international drug conventions protect public health?' (2012) 379 Lancet 84, 84.
[602] ibid.

prohibition as a policy strategy has also been subject to sustained criticism in the literature,[603] and calls for reforming drug control policy away from global prohibition are plentiful.[604]

In light of this, there is very little EU law to draw upon in the field of psychotropic drug control, from the perspective of analysing the contribution of the EU to the public health and social protection aspects of addiction prevention. The little EU coordination in the field of drug control that does exist, the EU having designated drug policy an area of subsidiarity, has been focussed on the prevention of crime.[605] Thus, given the dearth of EU law in the field, the fact that this thesis adopts a public health and social protection approach to addiction prevention, and given the inflexible and arguably ineffective nature of global prohibition and the widespread criminalisation of drug use and users, it will be difficult to conduct a meaningful analysis of the efficacy of the EU's contribution to addiction governance in this field.

This is not to say that the conclusions of this thesis will be inapplicable to psychotropic drugs. While it is true that psychotropic drugs are not subject to the free market, this does not mean that the operation of the free market is not responsible in part for generating the conditions in which an individual might turn to an addictive relationship with psychotropic drugs. According to the addictiogenic environment model of addiction, all addictions, whatever the manifestation, are an adaptation in response to social dislocation arising from the individual's environment, an adaptation which is made easier by environmental factors that increase the pseudo-relationship capacity of potential objects of addiction and which facilitate their vocational consumption. Addictions that manifest themselves in relation to psychotropic drug use still fit this model of addiction irrespective of whether the use of psychotropic drugs is criminalised or not – individuals addicted to psychotropic drugs have still experienced social dislocation,[606] are still engaging in a pseudo-relationship with their object of addiction,[607] and (despite the illegality of their actions) have still had vocational consumption of that object facilitated.[608]

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[603] Leitzel, n 55 above; J Gray, *Why Our Drug Laws Have Failed and What We Can Do About It: A Judicial Indictment of the War on Drugs* (Philadelphia, Temple University Press 2001).

[604] R MacCoun et al, 'Assessing Alternative Drug Control Regimes' (1996) 15(3) Journal of Policy Analysis and Management 330; A Kreit, 'Beyond the Prohibition Debate: Thoughts on Federal Drug Laws in an Age of State Reforms' (2010) 13 Chapman Law Review 555.

[605] On this subject, see: C Chatwin, 'Multi-level governance: the way forward for European illicit drug policy?' (2007) 18(6) International Journal of Drug Policy 494.

[606] J March et al, 'Drugs and social exclusion in ten European cities' (2006) 12(1) European Addiction Research 33.

[607] See the discussion in: T Goldberg, *Demystifying Drugs: A Psychosocial Perspective* (Basingstoke: Palgrave MacMillan 1999) from 60.

[608] See for example: H Parker et al, *Illegal Leisure: The Normalization of Asolexcent Recreational Drugs Use* (London: Routledge 1998).

Thus, a comprehensive holistic, horizontal and multilevel addiction strategy should be able to reduce preventable addiction to psychotropic drugs just as much as any other preventable addiction. The fact, however that trade in psychotropic drugs has been outlawed by the global prohibition regime makes it difficult to analyse whether control over the addictiogenic environment is being achieved with any effectiveness at EU level, since this is not the current objective of drug control in Europe.[609] For this reason, psychotropic drugs are not included as focus fields of this chapter, however one must keep in mind that this does not mean that addictions to psychotropic drugs, as a manifestation of the addiction phenomenon, are to be excluded from the conclusions that are drawn from the analysis conducted in this thesis.

By analysing the direct and indirect contributions of EU law to addiction governance across the three chosen focus fields of tobacco, alcoholic beverages and gambling services, this chapter seeks to show that the EU has been poor in providing a supranational regulatory environment in which the Member States can build addiction strategies that reflect the principles of holisticism, horizontality and multilevel governance. The direct contribution of EU law through secondary legislation and soft-law strategies has been erratic – opportunities to mainstream addiction concerns into other policy fields are rarely seized, and interventions have not always made best use of the available evidence. Interventions that do promote mainstreaming and are evidence-based have tended to be confined to the tobacco field, the only field in which true political consensus has been generated. Consequently, holisticism and horizontality are certainly not promoted by what little EU addiction policy there is. The indirect contribution of EU law – scrutiny of national rules by the CJEU for compatibility with EU internal market provisions and general principles of EU law – has often proved a confounding influence upon the ability of the Member States to adopt their desired addiction interventions. CJEU jurisprudence, particularly in the alcohol and gambling fields where EU harmonisation measures are virtually absent, has generally speaking hindered an appropriate multilevel allocation of responsibility for addiction policy, as Member States have often been prevented from discharging responsibilities that they are perhaps more suited to discharging, or from adopting measures that cater to their own national circumstances.

[609] On the current objectives of drug policy in European countries and at EU level, see: C Chatwin, 'Have recent evolutions in European governance brought harmonisation in the field of illicit drugs any closer?' (2010) 10(4) Drugs and Alcohol Today 26.

II. Tobacco

Tobacco control has been the field in which the EU has been most active in terms of NCD prevention, as well as in terms of addiction prevention. To date, the EU has enacted four pieces of secondary legislation that contribute to discharging supranational responsibility for addiction policy – the Tobacco Products Directive,[610] the Tobacco Advertising Directive,[611] the Tobacco Excise Directive,[612] and the Council Recommendations on Smoke-Free Environments.[613] In addition, the EU has also organised educational awareness campaigns on the health risks of tobacco since 2005.[614]

Multilevel governance in controlling the factors of the addictiogenic environment requires that the level of authority most suited to accomplishing a particular task should assume responsibility for undertaking those tasks.[615] The EU has been undertaking initiatives in the tobacco control field for over thirty years, and in that time has been relatively active in discharging its responsibilities for contributing to policymaking where supranational action is necessary.[616] A notable number of harmonisation measures have been enacted in the tobacco field, covering a good range of addictiogenic environment factors,[617] and the capacity of tobacco to be an object of addiction has been expressly recognised and addressed. The Tobacco Advertising Directive acknowledges that tobacco products have 'high potential to create addiction',[618] which in their capacity as an 'addictive product' is noted to be 'responsible for over half a million deaths in the [EU] annually'.[619] The Tobacco Products Directive also recognises the potential for non-traditional tobacco products, such as electronic cigarettes, to be objects of addiction.[620] Although the EU's tobacco policy is not expressly focussed on addiction, certain harmonised rules appear to be directly and specifically

[610] Directive 2014/40/EU, n 593 above.
[611] Directive 2003/33/EC, n 592 above, p. 16.
[612] Directive 2010/12/EU, n 492 above, p. 1.
[613] Council Recommendation on smoke-free environments [2009] OJ C 296, 5.12.2009, p. 4.
[614] The 'HELP' campaign from 2005-2010 and the 'Ex-Smokers and Unstoppable' campaign from 2011-2016. See: http://ec.europa.eu/health/tobacco/ex_smokers_are_unstoppable/index_en.htm (last accessed 1 July 2016).
[615] H Amundsen et al, 'Overcoming barriers to climate change adaptation – a question of multilevel governance?' (2010) 28(2) Environment and Planning C: Government and Policy 276, 280.
[616] See the analysis of the EU's contribution to multilevel tobacco control governance in: Asare et al, n 582 above, 85.
[617] Factors that promote the development of addiction are addressed through recommending that smoking be prohibited in certain social spaces; factors that encourage the development of addiction are addressed through restricting the possibilities to advertise tobacco, raising the price of tobacco through setting minimum taxation floors, and reducing the possibility for tobacco products to be made more attractive or palatable through various novel ingredients.
[618] Directive 2003/33/EC, n 592 above preamble para 7.
[619] ibid, preamble para 3.
[620] Directive 2014/40/EU, n 593 above, preamble para 43.

concerned with tobacco's potential to become an object of addiction, which indicates that EU tobacco policy is addressing certain factors of the addictiogenic environment. For example, Member States are required to 'on the basis of scientific evidence, prohibit the placing on the market of tobacco products containing additives in quantities that increase the toxic or addictive effect of those products',[621] a policy which addresses the fact that economic operators may try to increase the appeal of tobacco through palatable flavours,[622] thus contributing to the pseudo-relationship potential of such products. Furthermore, the packaging of electronic cigarettes is required to carry warning labels attesting to the addictive nature of nicotine',[623] a policy which addresses the fact that cigarette manufactures may be attempting to re-normalise smoking behaviour[624] through the promotion of less hazardous nicotine delivery mechanisms, in order to recreate an environment in which smoking can become an acceptable vocation.

The CJEU have supported the legitimacy of such action, which has been based on the EU's internal market harmonisation powers in Article 114 TFEU. After establishing that the EU's harmonisation competence can only be used for public health interventions that also genuinely have as their objective the targeting of problems with a cross-border dimension,[625] the CJEU held in *Tobacco Advertising 2* that the cross-border nature of tobacco advertising legitimised the use of Article 114 TFEU by the EU legislature to create harmonised standards prohibiting the advertising of tobacco products across television, radio, printed press and information society media.[626] In *Poland v Parliament and Council*, in which the 2014 Tobacco Products Directive was challenged, particularly with regard to the prohibition on characterising flavourings, the CJEU was progressive in factoring the EU's international public health commitments into its decision. On the basis that the EU is a party to the legally binding Framework Convention on Tobacco Control (FCTC),[627] and that the FCTC obliges parties to pursue a number of evidence-based tobacco control initiatives, the CJCEU held that the EU was entitled to pursue its ban on characterising tobacco flavours. It also held that Article 114 TFEU was an appropriate legal basis for the measure since its objective was, in addition to public health goals, to prevent regulatory disparities from emerging between the Member States.[628]

[621] ibid, Article 7(9).
[622] K Manning et al, 'Flavoured cigarettes, sensation seeking and adolescents' perceptions of cigarette brands' (2009) 18 Tobacco Control 459.
[623] Directive 2014/40/EU, n 593 above, Article 20(4)(b)(iii).
[624] A Fairchild et al, 'The renormalization of smoking? E-cigarettes and the tobacco "endgame"' (2014) 370(4) New England Journal of Medicine 293.
[625] See the judgement in *Germany v Parliament and Council*, n 465 above, para 84.
[626] Case 380/03 *Germany v Parliament and Council* [2006] ECLI:EU:C:2006:772, paras 53-68.
[627] Framework Convention on Tobacco Control (21 May 2003, entered into force 27 February 2005) 2303 UNTS 166.
[628] *Poland v Parliament and Council*, n 398 above, para 36.

Despite consistent recognition that the EU is permitted to use its harmonisation competence for public health purposes, direct recognition that the EU *should* use these competences has been rare in the CJEU's public health jurisprudence.[629] Therefore the *Poland v Parliament and Council* ruling represents an important milestone in establishing that the EU is responsible for the control of transnational factors of the addictiogenic environment[630] – which in this instance was the manipulation of potential objects of addiction by economic operators and their subsequent trade across borders, the transnational element being the fact that economic operators might take advantage of less stringent tobacco product regulations in one Member State in order to trade in more attractive tobacco products across the internal market.

The CJEU have not only supported the EU in its efforts to take responsibility for transnational aspects of tobacco addiction policy, they have also supported the Member States in adopting strong interventions that are either more appropriately adopted at the national level or are currently too divisive to adopt at EU level. In particular, the CJEU has upheld Member State interventions on the price of tobacco products. For example a very recent judgement upheld the legitimacy of a form of minimum pricing of tobacco, which mandated that tobacco products could not be sold below the recommended retail price set by the manufacturer.[631] This measure was held to fall outside the prohibition on measures having equivalent effect to a quantitative restriction altogether, and thus was not in conflict with EU rules on the free movement of goods.[632] By way of further example, the CJEU has also upheld legislation fixing certain rates of excise duties on the sale of cheaper tobacco products.[633]

The EU's interventions in the field of tobacco control also demonstrate an effort, within that field at least, to encourage horizontal policy thinking. As noted above, EU tobacco legislation covers a number of different fields – the advertising of tobacco products, the composition of tobacco products, and the price of tobacco products – at the very least indicating a desire to address tobacco control issues on several fronts at EU level. The CJEU's case law has also provided promising support

[629] Case Case C-544/10 *Deutsches Weintor* [2012] ECLI:EU:C:2012:526 is an example of such a rare occurrence, in which the CJEU relied on the EU's obligations under Article 35 of the EU Charter of Fundamental Rights to pursue a high level of public health protection in all its policies to uphold health claims legislation. See A Alemanno and A Garde, *Regulating Lifestyles in Europe: How to Prevent and Control Non-Communicable Diseases Associated with Tobacco, Alcohol and Unhealthy Diets?* (Swedish Institute For European Policy Studies, Report Number 7, 2013), 51.

[630] See the FCTC secretariat reaction to the CJEU decision at http://www.who.int/fctc/mediacentre/news/2016/legal-victories-against-tobacco-industry/en/ (last accessed 4 July 2016).

[631] Case C-221/15 *Etablissements FR. Colruyt NV* [2016] ECLI:EU:C:2016:704.

[632] ibid, paras 38-41.

[633] Case C-428/13 *Yesmoke Tobacco* [2014] ECLI:EU:C:2014:2263.

for horizontal action on addictive objects at EU level. First, the Court has upheld the validity of pursuing public health objectives through other policy fields – for instance it has stated several times that fiscal measures, taxation in particular, are important instruments of tobacco control.[634] Furthermore, the Court has consistently recognised in its tobacco control case law that the EU has an obligation to mainstream public health concerns – in other words to ensure that 'health protection must be considered in all fields of Union action'[635] – and has used this obligation to support internal market harmonisation measures that support public health objectives.

For example, in *Tobacco Advertising 2* the Court noted that, due to the mainstreaming provisions, the exclusion of harmonisation in the field of tobacco and alcohol under the EU's specific public health competence in Article 168(5) 'does not mean, however, that harmonising measures adopted on the basis of other provisions of the Treaty cannot have any impact on the protection of human health'.[636] Furthermore, the Court relied on a combination of the mainstreaming provisions in Article 168(1) TFEU and Article 114(3) TFEU in upholding the legitimacy of the Tobacco Products Directive.[637] Thus, in the tobacco control field, the EU legislature has taken some encouraging steps in pursuit of the mainstreaming obligations imposed by the Treaty, supported by the CJEU. Although the internal market competence could still be used as the foundation for far more action in tobacco control,[638] and despite the fact that health impact assessment in EU policymaking has so far been poor,[639] the progress made so far in the tobacco field could, arguably, be seen as an embryonic horizontal approach to governing this particular object of addiction.[640]

How can the EU's relative success in the tobacco field at promoting policies that target important factors of the addictiogenic environment be explained? Current successes can be traced back to the steady accumulation of evidence that irrefutably showed that smoking is not only harmful to individual health, but also a critical population health issue, which has grown to epidemic proportions.[641] The mounting evidence on the need for strong action at international level

[634] ibid, para 35; Case C-571/08 Commission v Italy [2010] ECLI:EU:C:2010:367, para 51; Case C-140/05 *Valeško* [2006] ECLIE:EU:C:2006:647, para 58.
[635] Alemanno and Garde, n 142 above, 1760.
[636] *Germany v Parliament and Council*, n 626 above, paras 95.
[637] *Poland v Parliament and Council,* n 398 above, para 35.
[638] R Bertollini et al, 'Tobacco control in Europe: a policy review' (2016) 25 European Respiratory Review 151;
[639] T Stahl, 'Is health recognized in the EU's policy process? An analysis of the European Commission's impact assessments' (2009) 20(2) European Journal of Public Health 176.
[640] See R Geyer and S Lightfoot, 'The strengths and limits of new forms of EU governance: The case of mainstreaming and impact assessment in EU public health and sustainable development policy' (2010) 32(4) Journal of European Integration 339, 346.
[641] See K Shibuya et al, 'WHO Framework Convention on Tobacco Control: development of an evidence based global public health treaty' (2003) 327 British Medical Journal 154, 155; G Lien and K DeLand, 'Translating the

precipitated a convergence in political agreement. A critical mass of supporters of tobacco control, state and non-state actors alike, began to agree that strong action on tobacco was in the shared interest of the international community.[642] Within the EU, the Tobacco Advertising Directive was finally enacted following decisive changes in government in Member States that had previously opposed tobacco legislation.[643] Similarly, the election of Gro Harlem Brundtland to the office of WHO Director General, with her committed tobacco control agenda, was the tipping point that ignited policy activity at WHO level.[644] The result was the adoption of the Framework Convention on Tobacco Control – a binding public health treaty that legally commits its signatories, of which the EU is one, to concerted, evidence based action to combat tobacco related harm – the existence of which has 'been employed as a catalyst to encourage broader participation in and engagement with tobacco control issues'.[645]

Although the adoption of the FCTC has 'generated global momentum for increased regulation of tobacco',[646] and in particular has provided crucial legal impetus for legitimising tobacco control at EU level,[647] the existence of the FCTC alone is not sufficient to ensure that EU policy action on tobacco and tobacco addiction will continue to develop in a horizontal, holistic and multilevel way. Aside from the concerns expressed in the literature on the implementation of the legal norms of the FCTC,[648] the greatest obstacle to the development of effective EU action on tobacco control remains the global tobacco industry. It is true that the image of legitimacy that the tobacco industry built for most of the twentieth century has been steadily eroded in recent years – revelations from internal tobacco industry documents,[649] class action litigation against the industry,[650] and the industry's

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WHO Framework Convention on Tobacco Control (FCTC): Can we use tobacco control as a model for other non-communicable disease control?' (2011) 125 Public Health 847, 849.

[642] On the building of this critical mass, and particularly the role of non-state actors in this process, see: H Mamudu et al, 'The Nature, Scope, and development of the Global Tobacco Control Epistemic Community' (2011) 101(11) American Journal of Public Health 2044.

[643] F Duina and P Kurzer, 'Smoke in your eyes: the struggle over tobacco control in the European Union' (2004) 11(1) Journal of European Public Policy 57.

[644] R Roemer et al, 'Origins of the WHO Framework Convention on Tobacco Control' (2005) 95(6) American Journal of Public Health 936, 938; H Mamudu and S Glantz, 'Civil society and the negotiation of the Framework Convention on Tobacco Control' (2009) 4(2) Global Public Health 150, 153.

[645] J Collin et al, 'The framework convention on tobacco control: the politics of global health governance' (2002) 23(2) Third World Quarterly 265, 275.

[646] O Cabrera and L Gostin, 'Human rights and the Framework Convention on Tobacco Control: mutually reinforcing systems' (2011) 7(3) International Journal of Law in Context 285, 290.

[647] Alemanno and Garde, n 142 above.

[648] Beaglehole et al, n5 above.

[649] L Bero, 'Implications of the Tobacco Industry Documents for Public Health and Policy'(2003) 24 Annual Review of Public Health 267.

[650] L Gostin, 'The "Tobacco Wars" – Global Litigation Strategies' (2007) 298(21) Journal of the American Medical Association 2537.

behaviour in reacting to regulation[651] have seen to this. However, the tobacco industry remains a powerful political player, and has used a number of overt and covert tactics to assert its influence over the policymaking process.[652] This has resulted in lengthy adoption processes for most EU tobacco interventions, which have ended up noticeably weaker on account of the industry's influence.[653] Thus, the industry has continued to influence policymaking despite the commitment the FCTC parties have made, under Article 5(3) to 'protect [these] policies from commercial and other vested interests of the tobacco industry in accordance with national law'. Full and rigorous implementation of this provision by the EU institutions should therefore be seen as a priority if EU tobacco control is to encourage further effective action on the factors of the addictiogenic environment.

In summary, the EU has made some good progress towards encouraging horizontal policymaking in the tobacco field, and by legislating in fields such as tobacco advertising and tobacco products has begun to take on responsibility where cross border trade presents issues. However, outside the tobacco control field the EU has been far less successful, and this chapter now turns to an analysis of EU efforts in the field of alcohol control.

III. Alcoholic Beverages

The EU has been far less successful in addressing addiction issues in the context of alcoholic beverages. The EU Alcohol Strategy, adopted in 2006 but now expired, codified the EU's policy making approach to alcohol.[654] Legislative interventions on alcohol are sparse - two Directives on alcohol excise duty were adopted over twenty years ago,[655] and the Audiovisual Media Services Directive contains some provisions that directly concern alcohol. Aside from these interventions, and in the absence of harmonisation in the field, control of alcoholic beverages has been left to the Member States.[656]

[651] T Oliver, 'The politics of public health policy' (2006) 27 Annual Review of Public Health 195.
[652] Y Saloojee and E Dagli, 'Tobacco industry tactics for resisting public policy on health' (2000) 78(7) Bulletin of the World Health Organization 902.
[653] M Neuman et al, 'Tobacco industry strategies for influencing European Community tobacco advertising legislation' (2002) 359 Lancet 1323; Costa et al, n 359 above.
[654] Commission Communication on an EU strategy to support Member States in reducing alcohol related harm COM(2006) 625 final.
[655] Directive 92/83/EEC of 19 October 1992 on the harmonization of the structures of excise duties on alcohol and alcoholic beverages OJ L 316/21, 31.10.1992; Directive 92/84/EEC of 19 October 1992 on the approximation of the rates of excise duty on alcohol and alcoholic beverages OJ L 316/29, 31.10.1992.
[656] The CJEU confirmed that 'in the present state of Community law, in which there are no common or harmonized rules governing in a general manner the advertising of alcoholic beverages, it is for the Member States to decide on the degree of protection which they wish to afford to public health and on the way on

The EU has been notably poor in responding to calls upon it to accept greater responsibility for action on addiction issues in the alcohol control field. From 2001 there have been multiple calls from the Member States for the EU to use its competences to provide support in tackling alcohol related harm,[657] including specifically on addiction issues, on which subject the 2001 Council Conclusions on a Commission Strategy to reduce alcohol related harm 'recalls the European Union Drugs Strategy 2000 to 2004 which emphasises the need for measures addressing addiction in general, including alcohol and tobacco'.[658] In the end, the EU Alcohol Strategy has provided nothing of the sort. Keen to respect the principle of subsidiarity in a policy field that is complex and highly contentious,[659] and in which socio-cultural arguments are often raised in order to stave off EU intervention,[660] the EU has operationalised the principle to extreme lengths.[661] For fear of infringing the subsidiarity principle, or perhaps as a convenient excuse to avoid action,[662] the EU Alcohol Strategy has been drafted in such a hands-off way that it provides virtually no useful supranational support to the Member States, especially on addiction issues.

First, the prospect of EU harmonisation measures is specifically excluded by the Strategy,[663] meaning that factors of the addictiogenic environment that operate across borders, such as the global alcohol industry, will remain unaddressed by coherent cross-border action, despite the Strategy recognising that 'where there is a cross border element, better coordination at, and synergies established with, the EU level might be needed'.[664] Second, as a Strategy that purported to respond to the 'need for further actions and cooperation at EU and national level',[665] the Strategy is remarkably sparse on

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which that protection is to be achieved': Joined Cases C-1/90 andC-176/90 *Aragonesa* [1991] ECLI:EU:C:1991:327, para 16.

[657] Council Conclusions of 5 June 2001 on a Commission Strategy to reduce alcohol related harm, OJ C 175/1, 20.6.2001.

[658] Council Recommendation 2001/458/EC of 5 June 2001 on the drinking of alcohol by young people, particularly children and adolescents [2001] OJ L 161/38 16.6.2001; Council Conclusions of 5 June 2001 on a Commission Strategy to reduce alcohol related harm [2001] OJ C 175/1, 20.6.2001; Council Conclusions of 1 June 2004 on alcohol and young people, 9507/04 (Presse 163); Council Conclusions on an EU strategy on the reduction of alcohol-related harm [2015] OJ C 418/6, 16.12.2015; European Parliament Resolution of 29 April 2015 on Alcohol Strategy (2015/2543(RSP)).

[659] R Gordon and P Anderson, 'Science and alcohol policy: a case study of the EU Strategy on Alcohol' (2011) 106(Suppl. 1) Addiction 55, 62.

[660] P Anderson and B Baumberg, *Stakeholders' views of alcohol policy* (London: Institute of Alcohol Studies 2005), 28-29.

[661] O Bartlett and A Garde, 'On the rocks? Some sobering thoughts on the growing EU alcohol problem' in T Hervey and A Young (eds), *Research Handbook in EU Health Law and Policy* (Cheltenham: Edward Elgar *forthcoming*).

[662] ibid.

[663] Commission Communication on an EU Alcohol Strategy, n 654 above, 4.

[664] ibid, 5.

[665] ibid.

novel, evidence based interventions – in fact the substance of the Strategy is primarily dedicated to summarising best practice that is already going on in the Member States.[666] This does nothing to fulfill the 'role of the EU as an overarching cooperative body',[667] when it has been requested to 'focus on measures with a European added value'.[668] This is especially so in relation to addiction issues. While addiction was specifically raised as an issue before the release of the Strategy, it contains only an isolated reference to the prevalence of alcohol addiction,[669] and vague assertions that EU action on certain cross-border factors of the addictiogenic environment such as alcohol advertising could be addressed in the future. Needless to say the EU has failed to address cross-border alcohol advertising,[670] and more recent calls for action from the Member States show that the few allusions to alcohol addiction have not led to a response that in any way discharges the supranational responsibilities of the EU to control transnational factors of the addictiogenic environment.[671]

The EU Alcohol and Health Forum, set up in 2007 as the 'cornerstone'[672] and driver of the Strategy's policy objectives at EU level, is also a disappointment. Although intended to be a mechanism to 'step up actions relevant to reducing alcohol-related harm'[673] – including, one would think, the issue of alcohol addiction – in reality the forum has become dominated by industry members who make most of the commitments, most of which are ineffective information provision interventions.[674] Asking industry operators that produce objects of addiction to regulate themselves in ways that reduce their profitability was always liable to introduce overwhelming conflicts of interest into the EU alcohol policymaking process.[675] Foreseeing this might have prompted EU policymakers to

[666] Gordon and Anderson, n 659 above, 62.
[667] ibid.
[668] Council Conclusions of 5 June 2001 on a Commission Strategy to reduce alcohol related harm, OJ C 175/1, 20.6.2001, para 17.
[669] Commission Communication on an EU Alcohol Strategy, n 654 above, 10.
[670] O Bartlett and A Garde, 'Time to seize the (red) bull by the horns: the EU's failure to protect children from alcohol and unhealthy food marketing' (2013) 38(4) European Law Review 498.
[671] European Parliament Resolution of 29 April 2015 on Alcohol Strategy (2015/2543(RSP)), preamble paragraph R.
[672] Charter establishing the EU Alcohol and Health Forum, available online at http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/Alcohol_charter2007.pdf (last accessed 11 July 2016), 2.
[673] ibid.
[674] O Bartlett and A Garde, 'The EU Platform and the EU Forum: new modes of governance or a smokescreen for the promotion of conflicts of interest' in A Alemanno and A Garde, *Regulating Lifestyle Risks: The EU, Alcohol, Tobacco and Unhealthy Diets* (Cambridge University Press 2015), 283. On the ineffectiveness of information provision interventions, see Anderson et al, n 156 above.
[675] P Adams et al, 'Vested Interests in Addiction Research and Policy Poisonous partnerships: health sector buy-in to arrangements with government and addictive consumption industries' (2010) 105(4) Addiction 585; S Casswell, 'Vested interests in addiction research and policy. Why do we not see the corporate interests of the alcohol industry as clearly as we see those of the tobacco industry?' (2013) 108(4) Addiction 680.

involve the alcohol industry on the basis of capacity, where 'agents who have the capacity to address a problem more effectively or efficiently should assume the responsibility to do so',[676] not on the basis of culpability, where 'agents who are to some degree "culpable" in a causal and moral sense, should take responsibility for the effects of their action'.[677] The EU Forum was, unfortunately, set up on contradictory terms – while Forum members should be 'capable of playing an active role in reducing alcohol-related harm'[678] the Founding Charter also invites 'all interested stakeholders … that pledge to step up actions relevant to alcohol related harm'.[679] The implications of universal Forum membership were not thought through, and the result has been that supranational policy responsibility has been given to stakeholders whose actions are a major cross-border factor of the addictiogenic environment. This breakdown in the allocation of policy responsibility resulted in the collapse of the Forum, when all participating public health NGOs resigned in protest at the above situation.[680] Consequently, there is currently no strategic direction at EU level on how the EU is to take responsibility for transnational factors of the addictiogenic environment pertaining to alcohol.

In the absence of EU action, the Member States have proceeded to address alcohol addiction according to their own priorities. As these policies usually restrict cross-border trade,[681] the CJEU is often called upon to assess the way in which Member States have balanced their free trade obligations with their concern, and indeed responsibility under the Treaties[682] and their WHO level commitments,[683] to reduce the prevalence of alcohol addiction. In light of the Member States' international public health responsibilities, the fact that in the absence of harmonisation the Member States may decide how and to what extent they wish to protect the health of their populations, and the fact that the EU appears to have abdicated its own responsibility for alcohol addiction governance, it might be reasonable to expect that the CJEU would maintain a margin of discretion with respect to the compatibility of Member State public health policies with the free movement provisions of the Treaty. As the Court stated in *Ahokainen and Leppik* in 2006:

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[676] S Karlsson, 'Allocating responsibilities in multi-level governance for sustainable development' (2007) 34(1/2) International Journal of Social Economics 103, 108.
[677] ibid.
[678] Charter Establishing the EU Alcohol and Health Forum, n 672 above 4.
[679] ibid 2.
[680] See the open letter tendering this resignation at http://www.ias.org.uk/uploads/pdf/Commissioner_Andriukaitis__resignation_EAHF.pdf (last accessed 11 July 2016).
[681] For an analysis on this point, see Bartlett and Garde, n 661 above.
[682] We should recall that Article 168 TFEU allocates primary responsibility for public health policy to the Member States.
[683] See the *Global Strategy to reduce the harmful use of alcohol* (World Health Organization 2010) and the *European action plan to reduce the harmful use of alcohol 2012-2020* (World Health Organization Regional Office for Europe 2012).

> 'Member States enjoy a margin of discretion in determining, having regard to the particular social circumstances and to the importance attached by those States to objective which are legitimate under Community law, such as the prevention of alcohol abuse … the measures which are likely to achieve concrete results'.[684]

However, the recent case law of the Court appears to remove this margin of discretion. Instead, the Member States are seemingly expected to *prove* that alcohol control measures that restrict trade, many of which also combat factors of the addictiogenic environment, are necessary.[685]

The legitimate objective of preventing alcohol addiction is directly acknowledged in several alcohol control cases, where the suitability of measures adopted to combat alcohol addiction is also upheld. In *Commission v France* and *Aragonesa*, advertising was recognised to be linked to addiction prevalence.[686] In *Heinonen* the Court recognised that addiction policy is part of Member States' wider efforts to protect public health.[687] Thus, the Court has built some awareness that a concern to address alcohol addiction requires certain policy actions, and can form part of a broader public health strategy. Unfortunately, this awareness has not been translated into an understanding of how difficult it is to prove that one element of a holistic policy approach is worth the restriction on trade that it specifically causes.[688] In fact, later cases seem to pay less heed to the place of addiction issues in Member States alcohol control policy, and do not appear to apply any margin of discretion – in *Rosengren* the CJEU declared that certain alcohol importation restrictions did not demonstrate an 'irreproachable level of effectiveness',[689] and in *Scotch Whisky* the CJEU effectively analysed whether minimum unit pricing could offer anything more to the pursuit of public health protection than taxation,[690] rather than whether the Member State was entitled to consider that the imposition of minimum unit pricing would strike a necessary balance between public health and free trade concerns. As a consequence, it is now significantly more difficult for Member States to justify bold alcohol addiction policies, due to the hard task of definitively proving the public health effects of very specific policies that are designed to operate as part of an overarching strategy, which itself

[684] Case C-434/04 *Ahokainen and Leppik* [2006] ECLI:EU:C:2006:609, para 32.
[685] See the analysis in Bartlett and Garde, n 661 above.
[686] Case C-152/78 Commission v France (alcohol advertising) [1980] ECLI:EU:C:1980:187, para 17; *Aragonesa*, n 656 above, para 17.
[687] Case C-394/97 *Heinonen* [1999] ECLI:EU:C:1999:308, para 33.
[688] Bartlett and Garde, n 661 above.
[689] Case C-170/04 *Rosengren* [2007] ECLI:EU:C:2007:313, para 54.
[690] *Scotch Whisky*, n 365 above, para 42-48.

may be balancing public health and trade issues.[691] This is particularly disappointing in light of the EU's refusal to accept responsibility for alcohol addiction issues. In terms of the allocation of policy responsibility to the appropriate level of authority, the CJEU's response to Member State alcohol policies has effectively led to the situation where some effective addiction interventions are barred at the national level, yet will not be compensated for by action at supranational level.[692] This is a serious impediment to the ability of Member States to deal with the complex nature of addiction policymaking, an impediment which the EU should take responsibility for resolving.

The EU institutions have not only disrupted the effective allocation of alcohol addiction policy to the most effective levels of authority, they have also failed to encourage the development of a horizontal approach to such policy. There are no references to addiction, alcoholism or dependence in any EU legislation outside of the EU Alcohol Strategy, and indeed public health concerns in general have been engaged with to a disappointingly low extent. The Television Without Frontiers Directive[693] and its successor the Audiovisual Media Services Directive were opportunities for the EU to lay down strong standards in its cross-border media and broadcasting policy that protected individuals, children in particular, from certain factors of the addictiogenic environment such as irresponsible alcohol advertising.[694] Instead, the limited number of the Directive's provisions that apply to alcohol are weak and easy to circumvent[695] – a situation that has prompted Member States to adopt more stringent rules, which in turn provides leads to further CJEU scrutiny, and further potential failures of multilevel governance.[696] Another notable failure to consider the potential contribution that other EU policies could make to alcohol control was the exclusion of alcoholic beverages from the scope of mandatory disclosure requirements that are imposed upon other

[691] Alemanno and Garde, n 142 above, 1752; A Garde, 'Freedom of Commercial Expression and Public Health Protection: The Principle of Proportionality as a Tool to Strike the Balance' in L Gormley and N Shuibhne, *From Single Market to Economic Union-Essays in Honour of John A Usher* (Oxford University Press 2012), 126.
[692] This is general trend across the EU's engagement in all most matters of alcohol control. See: Bartlett and Garde, n 661 above.
[693] Directive 89/552/EEC of 3 October 1989 on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the pursuit of television broadcasting activities, OJ L 298/23, 17.10.1989.
[694] See: Does marketing communication impact on the volume and patterns of consumption of alcoholic beverages, especially by young people? – a review of longitudinal studies (Scientific Opinion of the Science Group of the European Alcohol and Health Forum 2009) available online at http://ec.europa.eu/health/ph_determinants/life_style/alcohol/Forum/docs/science_o01_en.pdf (last accessed 11 July 2016).
[695] Bartlett and Garde, n 670 above.
[696] See the assessment of the CJEU – fortunately in favour of public health interests in this situation – of French rules prohibiting the advertising of alcohol on television: Case C-262/02 *Commission v France (loi evin)* [2004] ECLI:EU:C:2004:431.

foodstuffs by Regulation 1169/2011.[697] As has been noted previously, Article 168(1) TFEU requires that 'a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities', while Article 114(3) TFEU requires that internal market proposals relating to health 'will take as a base a high level of protection'. The EU's failure to act on these mainstreaming obligations stands in stark contrast to its work in the tobacco control field, and is made all the more noticeable by the fact that the EU Alcohol Strategy has expired, leaving these few legislative provisions as the EU's only concrete engagement with alcohol control issues, let alone alcohol addiction issues.

How can the disparity between the EU's alcohol control and tobacco control efforts be explained? How could two objects that may equally become objects of addiction come to be treated by the EU institutions so differently. A significant factor is the difference between the sociocultural role of alcohol compared with tobacco, which has resulted in political agreement being far more difficult to reach in the alcohol control field than in the tobacco control field. Alcohol, unlike tobacco, is a far more heterogeneous product than tobacco. The variety of alcoholic beverages produced and marketed within Europe is enormous,[698] with types and methods of alcohol consumption also varying considerably between Member States.[699] This heterogeneity is often raised by stakeholders to support arguments that the regulation of alcoholic beverages within Europe should be guided by the subsidiarity principle.[700] These circumstances have meant that it has been very difficult to generate political agreement on what common regulations could be applied to alcohol at the supranational level. States are simply not yet prepared to make the necessary effort to identify commonalities between how they approach alcohol, agree common standards of protection to which they can all subscribe, and engage in policymaking that would formalise these common commitments.[701] What are now well established policymaking conditions in the tobacco field and which led to the creation of the FCTC, are sadly absent in the alcohol control field. This goes some way to explaining the failure of the EU to engage with its supranational responsibilities in alcohol addiction policymaking, and means that the prospect of binding EU rules is somewhat distant.

Another significant factor that may explain the lack of progress on alcohol control compared with tobacco is that the alcohol industry is still seen by the EU and its Member States as a partner to be

[697] Regulation 1169/2011 of the European Parliament and of the Council of 25 October 2011 on the provision of food information to consumers, OJ L 304/18, 22.11.2011, Article 16(3).
[698] Anderson and Baumberg, n 25 above.
[699] R Gordon et al, 'Rethinking drinking cultures: A review of drinking cultures and a reconstructed dimensional approach' (2012) 126 Public Health 3.
[700] Anderson and Baumberg,n 660 above, 28.
[701] S Casswell and T Thamarangsi, 'Reducing harm from alcohol: call to action' (2009) 373 Lancet 2247.

trusted, rather than a vector of disease[702] to be controlled at arm's length.[703] As discussed above, the tobacco industry has been relegated to near pariah status, enabling most policymakers to agree upon the fact that it should be excluded from policymaking. The alcohol industry by comparison is not yet seen as a pariah – in fact, despite similarities with the tobacco industry in how it operates to weaken policy, the alcohol industry is still trusted as a policy partner,[704] has been actively invited into policy discussions at European level as we saw from the above discussion on the EU Alcohol Forum, and is still allowed to co-opt debates and influence government positions on policy from a privileged position.[705] Thus, the industry has been allowed to steer debates on addiction towards the issue of personal responsibility[706] and away from their own substantial contribution to the addictiogenic environment, which has resulted in the policymaking process loosing focus[707] on effective interventions in a way that has not been allowed to happen for tobacco.

In summary, the EU has responded poorly to calls for it to accept greater policymaking responsibility in the alcohol control field, and this has meant that supranational addiction issues relating to alcohol have been left virtually untouched. The way in which the CJEU's alcohol case law has developed has also made the Member States' job of dealing with addiction issues more difficult. By comparison, the EU's efforts in the field of gambling services serve as an even more interesting litmus test of the EU's approach to the addiction phenomenon, and it is to an analysis of these efforts that this chapter now turns.

IV. Gambling Services

Gambling is perhaps even more sensitive as an addiction issue than alcohol[708] – as Van den Bogaert and Cuyvers put it, 'how to regulate an activity which is perceived as morally objectionable and

[702] Gilmore et al, n 294 above.
[703] Casswell, n 675 above.
[704] For a particularly good example of the potential conflicts of interest generated by such partnerships, and the implications for public health, see: G Munro, 'An addiction agency's collaboration with the drinks industry: *Moo Joose* as a case study' (2004) 99(11) Addiction 1370.
[705] For example, see the revelation that the UK government reversed its intention to adopt minimum unit pricing in England following extensive secret meetings with the alcohol industry: J Gornall, 'Under the influence' (2014) 348 British Medical Journal f7646.
[706] See: B Hawkins and C Holden, 'Framing the alcohol policy debate: industry actors and the regulation of the UK beverage alcohol market' (2013) 7(1) Critical Policy Studies 53.
[707] See for example the following analysis of the influence of the alcohol industry on UK alcohol policy, which arguably focusses on interventions for which the evidence is weak: Hawkins et al, n 359 above.
[708] See the Conclusions of the Swedish Council Presidency on gambling, which states that 'the Presidency believes that the Member States have an interest and right to regulate and control their gambling markets in accordance with their traditions and cultures': Presidency progress report of 3 December 2009, (doc ref 16571/09).

socially harmful, yet which generates significant revenue (often earmarked for desirable social purposes) and seems impossible to prevent anyway?'.[709] In the case of an object of addiction that is not only perceived differently between Member States, but which many Member States directly organise and profit from, it is extremely difficult for EU level policymakers to build consensus for a common European regulatory approach. Due to the fact that many governments profit greatly from gambling through state-run monopolies, any effort to set common standards of social or health protection 'would be met by enormous political resistance from those groups that would lose from harmonization'.[710] The difficulty of regulating gambling at EU level is further increased when one considers that, unlike products that have the capacity to move across borders, services provided exclusively within the national territory, such as land based casinos, do not have a strong cross-border dimension. Despite the fact that travelling across borders to receive gambling services in other Member States gives such services a cross-border dimension,[711] land-based gambling services are, practically speaking, beyond the scope of EU policymaking.[712]

Consequently, EU policy makers are limited in options, and therefore have not sought to harmonise any aspect of gambling services provision. The only field in which the Commission has been able to put forward policymaking proposals is online gambling. In 2011 the Commission published a Green Paper on online gambling in the Internal Market,[713] and in 2012 adopted a Communication on the same topic.[714] These documents raised the point that online gambling takes place in an 'inherently cross-border environment',[715] and that due to the 'development of the internet and the increased supply of on-line gambling services'[716] it is 'more difficult for the different national regulatory models to co-exist'.[717] On this basis, following the release of the Green Paper and the Communication, the Commission adopted a Recommendation on the subject,[718] which aims to 'safeguard the health of consumers and players and … minimise eventual economic harm that may

[709] S Van den Bogaert and A Cuyvers, '"Money for nothing": The case law of the EU Court of Justice on the Regulation of Gambling' (2011) 48 Common Market Law Review 1175, 1175.
[710] F Scharpf, 'Introduction: the problem solving capacity of multi-level governance' (1997) 4(4) Journal of European Public Policy 520, 530.
[711] Case C-243/01 *Gambelli* [2003] ECLI:EU:C:2003:597.
[712] A Littler, *Member States versus the European Union: The Regulation of Gambling* (Leiden: Martinus Nijhoff 2011), 228.
[713] Green Paper on on-line gambling in the Internal Market, COM(2011) 128 final.
[714] Commission Communication, Towards a comprehensive European framework for online gambling, COM(2012) 596 final.
[715] ibid.
[716] Green Paper, n 713 above, 3.
[717] ibid.
[718] Commission Communication on online gambling in the internal market, n 714 above.

result from compulsive or excessive gambling'[719] by setting out 'principles for a high level of protection of consumers, players and minors as regards online gambling services'.[720] Further EU engagement with gambling policy extends to two European Parliament Resolutions on Online Gambling from 2011[721] and 2013,[722] a set of Council Conclusions on Online Gambling,[723] and the establishment of an Expert Group on Gambling.[724]

In quantitative terms, the EU's engagement with gambling appears even more sparse than with alcohol. However, in a field as complex, morally charged and sensitively balanced as gambling, in which building the necessary consensus for regulation at international level is incredibly difficult, a successful multilevel governance approach does not necessarily mean that all levels must legislate. Harmonisation represents only one way in which the EU might discharge its responsibilities for addressing transnational addiction factors.[725] Thus, despite the difficulties in creating harmonised gambling control standards, the EU legislature has made reasonable efforts to discharge its responsibilities to assist the Member States in addressing gambling addiction issues of a cross-border nature.

The EU has engaged in a genuine process of consultation, implementation and feedback, in order to respond to calls that were made by successive European Council presidencies from 2008 to 2010[726] and the European Parliament in 2009[727] for EU level action on cross-border gambling services. The publication of the Green Paper was welcomed by the European Parliament as a step that would 'facilitate pragmatic and realistic consideration of the future of [online gambling] in Europe'.[728] The Commission was therefore attentive to the calls from Member States, and the need for action at the

[719] ibid.
[720] ibid.
[721] European Parliament resolution of 15 November 2011 on online gambling in the Internal Market (2011/2084(INI)).
[722] European Parliament resolution of 10 September 2013 on online gambling in the internal market (2012/2322(INI)).
[723] Council Conclusions of 10 December 2010 on the framework for gambling and betting in the EU Member States, Council document 16884/10.
[724] See the Register of Commission Expert Groups, available online at http://ec.europa.eu/transparency/regexpert/index.cfm?do=groupDetail.groupDetail&groupID=2868 (last accessed 12 July 2016).
[725] See: C Scott, 'The Governance of the European Union: The Potential for Multi-Level Control' (2002) 8(1) European Law Journal 59.
[726] From the French Presidency in its Presidency progress report of 1 December 2008 (doc ref 16022/08); from the Swedish Presidency in its Presidency progress report of 3 December 2009, (doc ref 16571/09); and from the Spanish Presidency in its Presidency progress report of 25 May 2010, (doc ref 9495/10).
[727] European Parliament resolution of 10 March 2009 on the integrity of online gambling (2008/2215(INI)).
[728] European Parliament resolution of 15 November 2011 on online gambling in the Internal Market (2011/2084(INI)), para 1.

supranational level. The publication of the Communication followed, which acknowledged that 'it does not appear appropriate at this stage to propose sector specific EU legislation', but recognised that 'there was an almost unanimous call for policy action at EU level'.[729] The Communication was designed to answer this call by encouraging Member States to adopt 'a combination of initiatives and relevant measures' that were 'based on available evidence'.[730] The Communication contains a section dedicated to 'preventing problem gambling or gambling addiction', which acknowledges that greater evidence is needed, including on 'the determinants' of gambling addictions – in other words the factors of the gambling addictiogenic environment.[731] Such evidence was indeed sought through the Commission co-funded ALICE RAP project, a recently concluded five year research project that aims to build a better understanding of how addiction is developed and what harm it causes.[732] Through this process, the Commission showed an appreciation of its role as a supranational policy entrepreneur[733] by reacting attentively to the requests of Member States in relation to gambling, and to gambling addiction, which was raised as a specific area of concern.[734]

Following the publication of the Communication, the European Parliament issued a further Resolution that offered positive feedback on the Commissions' efforts,[735] but ultimately requested further action, particularly to include provisions recommending that Member States mandate that advertising for online gambling must carry warnings on the risk of gambling addiction. The Parliament 'call[ed] on the Commission and the Member States to introduce effective measures to raise awareness of the risks of gambling addiction',[736] yet did not envisage proposals for harmonisation to be part of this.[737] The Commission's response was the publication of its Recommendation on online gambling. This Recommendation notes and acts upon the calls for greater action on gambling addiction[738] – multiple provisions of the Recommendation pertain to the prevention of problem gambling specifically, or to important factors of the addictiogenic environment for gambling, so much so that one could consider problem gambling to be one of the

[729] Commission communication on online gambling in the internal market, n 714 above, 3.
[730] Commission communication on online gambling in the internal market, n 714 above, 4.
[731] Commission communication on online gambling in the internal market, n 714 above, 11-12.
[732] See the ALICE RAP website: http://www.alicerap.eu (last accessed 12 July 2016).
[733] See: Batory and Lindstrom, n 390 above, 312.
[734] See the Conclusions of the Swedish Presidency Conclusions at p 3; Spanish Presidency conclusions at p 10.
[735] European Parliament Resolution of 2013, n 722 above, para 20.
[736] ibid para 23.
[737] Paragraph D of the resolution envisages that human health should be protected through 'EU –level recommendations and national legislation'. Furthermore, paragraph E states that 'with due regard to the principle of subsidiarity, Member States have the right to determine how the offer of online gambling services is organised and regulated in accordance with their own values and pursued objectives of general interest, while observing Union law'.
[738] European Parliament Resolution of 2013, n 722 above, 3.

driving concerns of the Recommendation. Indeed under Article 1, one purpose of the Recommendation is to 'safeguard health and to also minimise the eventual economic harm that may result from compulsive or excessive gambling'. The Commission indeed encourages Member States to ensure that gambling advertising carries warnings on problem gambling risks,[739] and recommends standards for the regulation of gambling advertising,[740] while encouraging Member States to ensure that economic operators have policies in place for identifying potential problem gamblers.[741] It furthermore recommends that gambling advertising should not target vulnerable individuals and in particular those who have had gambling problems.[742]

The Recommendation can be seen as offering supranational coordination that directly addresses several important aspects of the addictiogenic environment for gambling,[743] and which is commensurate with the action requested by the Member States and the powers available to the Commission. One might therefore conclude that, in the gambling sector, the EU has gone some way towards discharging its responsibilities for addressing transnational factors of the addictiogenic environment. This is interesting given that the political sensitivity of the gambling field is even greater than in the alcohol or tobacco fields. There is certainly evidence that the Commission has made an effort to discharge its supranational responsibilities despite its limited ability to adopt legislation, in contrast to the alcohol field where the Commission has actively resisted the calls of the Member States for action despite its capacity for legislative action.

One might legitimately ask how the Commission has managed to discharge its responsibilities in relation to gambling services, while actively resisting them in relation to alcoholic beverages. Putting these limited successes in their broader regulatory perspective shows that the above progress may be rather meagre in context. It should be recalled that the Communication and the Recommendation released by the Commission are both non-binding instruments, as requested by the Member States. This in itself perhaps explains why the Commission was able to propose such extensive and direct recommendations for action. Free from having to build the political consensus

[739] Commission Recommendation 2014/478/EU of 14 July 2014 on principles for the protection of consumers and players of online gambling services and for the prevention of minors from gambling online, OJ L 214, 19.7.2014, p. 38–46, Article 40.
[740] ibid, Article 31.
[741] ibid, Article 30.
[742] ibid, Article 43.
[743] These include child protection, information disclosure, availability, player welfare and marketing. See: S Planzer et al, 'Associations between national gambling policies and disordered gambling prevalence rates within Europe' (2014) 37 International Journal of Law and Psychiatry 217.

necessary for Member States to agree to bear the 'costs of regulation',[744] the Commission was able to go far further with its suggestions than it would have been able to had it been called upon to initiate proposals for harmonisation. The absence of any desire for binding legislation in the gambling field of course means that the EU's ability to mainstream gambling addiction issues into other EU policy fields is extremely limited, and is evidenced by the fact that gambling services have been specifically excluded from the scope of the Services Directive,[745] the E-Commerce Directive,[746] and the Audiovisual Media Services Directive,[747] three important pieces of internal market legislation that could otherwise have contributed to resolving conflicts between competing market liberalisation and consumer protection imperatives.[748] Furthermore, other pieces of EU secondary legislation that are applicable to gambling have been revealed as not imposing any strong controls on gambling services.[749] Consequently, the total lack of desire for harmonised standards at EU level in the gambling field can be seen as something of a double edged sword – while giving the Commission freedom to discharge supranational level responsibilities using non-binding mechanisms, it also appears to have shut down its ability to promote horizontality in the governance of gambling addiction issues.

Thus, it could be argued that the EU's policy engagement with gambling addiction issues is almost the reverse of its engagement with alcohol addiction issues. Despite the fact that Member States guard their ability to regulate gambling services even more jealously than they do their ability to regulate alcoholic beverages, which therefore should have demanded an ever more subservient response from the Commission, in actual fact the Commission has been freed from virtually any legislative responsibility. In the place of common European standards, the Commission has therefore created an extensive yet relatively superficial set of soft-law measures, more reminiscent of a wish list than an actual effort to coordinate Member State action. Thus, while the Commission has shown intent to discharge responsibility for supranational action on the factors of the addictiogenic environment, the direct impact of this intent upon transnational factors of the addictiogenic environment in the gambling field may be quite minimal.

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[744] A Heritier, 'New Modes of Govenancein Europe: Policy-Making without Legislating?' (2001) MPI Collective Goods Preprint No. 2001/14, available online at http://dx.doi.org/10.2139/ssrn.299431 (last accessed 13 July 2016), 4.

[745] Directive 2006/123/EC of 12 December 2006 on services in the internal market, OJ L 376/36, 27.12.2006, Article 2(2)(h).

[746] Directive 2000/31/EC of 8 June 2000 on certain legal aspects of information society services, in particular electronic commerce, in the Internal Market, OJ L 178/1, 17.7.2000, Article 1(5)(d).

[747] Directive 2010/13/EU of 10 march 2010 on Audiovisual Media Services, OJ L 95/1, 15.4.2010.

[748] S Kingma, 'The liberalization and (re)regulation of Dutch gambling markets: National consequences of the changing European context' (2008) 2 Regulation and Governance 445, 454.

[749] A Littler, 'Regulatory perspectives on the future of interactive gambling in the internal market' (2008) 33 European Law Review 211, 221-225.

Due to the fact that there is no harmonisation at EU level in the gambling field, Member States are free to regulate gambling services as they see fit,[750] provided they do so within the bounds of the Treaty provisions on the freedoms of establishment and services,[751] and the principle of proportionality.[752] As highlighted above, gambling services are unusual objects of addiction because Member States may be financially conflicted over gambling regulation in a way that they are not over alcohol and tobacco regulation. This has an impact upon gambling regulation, since Member States will have an incentive to encourage some manner of expansion of gambling opportunities.[753] Consequently, the CJEU has had an opportunity in its gambling case law, which has been extensive since the first preliminary reference in *Schindler* in 1992,[754] to provide clarification on the balance that must be struck under EU law between economic gains, public health protection, and free movement in the regulation of gambling services.

However, the CJEU's case law has done anything but clarify the responsibilities and obligations of the Member States in relation to the governance of gambling addiction. The CJEU's assessment of whether restrictions on the free movement of services[755] and the freedom of establishment[756] made by gambling regulation can be justified revolves, as with alcohol control, around whether national measures are suitable and necessary to achieve legitimate objectives.[757] In *Gambelli* the CJEU accepted, based on the decisions in *Schindler*, *Laara* and *Zenatti*, that consumer protection (subsequently interpreted to include addiction[758]) and the prevention of crime could constitute legitimate objectives that would justify restrictions on services and establishment.[759] By reading the judgements in *Zenatti*, *Gambelli* and *Placanica* together, gambling regulation will be suitable for achieving either of those objectives when it aims at a genuine diminution of gambling opportunities[760] in a consistent and systematic manner[761] and employs methods that are necessary to achieve such consistency.[762]

[750] Case C-42/07 *Liga Portuguesa* [2009] ECLI:EU:C:2009, para 57.
[751] C Barnard, 'Unravelling the Services Directive' (2008) 45 Common Market Law Review 323, 343.
[752] Case C-338/04 *Placanica* [2007] ECLI:EU;C:2007:133, para 48.
[753] C Jensen, 'Money over misery: restrictive gambling legislation in an era of liberalization' (2016) Journal of European Public Policy DOI: 10.1080/13501763.2016.1146326, 3.
[754] Case C-275/92 *Schindler* [1994] ECLI:EU:C:1994:119.
[755] Protected by Article 56 TFEU.
[756] Protected by Article 49 TFEU.
[757] *Gambelli*, n 711 above, para 65.
[758] Case C-203/08 *Sporting Exchange* [2010] ECLI:EU:C:2010:307, para 30.
[759] *Gambelli*, n 711 above, para 67.
[760] Case C-67/98 *Zenatti* [1999] ECLI:EU:C:1999:514, para 36.
[761] *Gambelli*, n 711 above para 67.
[762] *Placanica*, n 752 above, para 55.

However in *Placanica*, the CJEU recognised that when a Member State seeks to expand the gambling opportunities it controls through a monopoly in order to increase tax revenue, the restrictions to services and establishment made by the monopoly cannot be justified by consumer protection (and addiction) concerns[763] – instead, they must be justified by concerns to combat crime.[764] In such a situation, when seeking to channel gamblers into a 'reliable, but at the same time attractive, alternative to a prohibited activity'[765] in an effort to combat crime, Member States may pursue a policy of controlled expansion, in order to ensure that their chosen gambling channel is indeed attractive.[766]

This outcome did not exactly cover the CJEU in glory – in essence the above case law provides Member States with a way to continue profiting from an object of addiction, as long as the way in which this is done is consistent with the prevention of crime. This was, at least, not contradictory. However, in *Ladbrokes*, the CJEU introduced exactly such a contradiction. The CJEU expressly rejected previous findings in *Laara* and *Placanica* that the channelling argument could only be used when the objectives raised to justify national gambling regulation that permitted expansions in gambling opportunities were related to the prevention of crime, not the prevention of addiction. *Ladbrokes* held that 'the fact remains that those two objectives must be considered together, since they relate both to consumer protection and to the preservation of public order'.[767] Despite the case law that the Court refers to in order to back up this claim, the fact remains – to use the CJEU's own words – that the channelling argument was specifically introduced into the proportionality analysis in relation to the objective of preventing crime only. Consequently, the Court erroneously continued on to hold in *Ladbrokes* that 'a fair balance has to be drawn between demand for the controlled expansion of authorised games of chance with the aim of making the provision of such games attractive for the public and the need to reduce as far as possible consumer addiction to such games'.[768]

The result is to advise Member States that, in order to be compatible with EU law, their rules must strike a balance between a practice that, at the CJEU's own admission, is 'in principle, difficult to

[763] ibid, para 54.
[764] ibid, para 55.
[765] ibid, para 55.
[766] ibid, para 55.
[767] Case 258/08 *Ladbrokes* [2010] ECLI:EU:C:2010:308, para 26.
[768] ibid, para 32.

reconcile'[769] with preventing gambling addiction, and an objective that was expressly acknowledged not to justify such a practice. The *Ladbrokes* case created a contradiction in the assessment of the proportionality of Member State policies on gambling addiction that has never been fully reconciled by subsequent CJEU case law. This is evidenced by the myriad variations of what is 'necessary' to ensure that channelling and controlled expansion is consistent with the prevention of addiction – examples include tolerating private expansion not subject to a monopoly while the monopoly is restricted,[770] advertising not being 'measured' in nature,[771] and the extent of unlawful activity not being 'significant'.[772] The consequence of this persistent contradiction is that Member State efforts to organise their approach to gambling addiction in a horizontal way have been seriously undermined. The Court had an opportunity to assist the Member States in balancing their financial conflict of interest in gambling regulation, but instead seem to have exacerbated it, expressly allowing Member States to continue drawing profit from their organisation of gambling opportunities despite the fact that this will not contribute effectively to controlling the addictiogenic environment.

The use of the channelling argument has had another undesirable side effect for addiction governance, in that the balance struck between the prevention of gambling addiction and free trade is not consistent with that struck in relation to other objects of addiction, notably alcoholic beverages. The CJEU has been consistent in holding that Member States are entitled to operate a state-owned or state-run monopoly on gambling in preference to open competition between private operators, in order to ensure that consumers are channelled towards gambling opportunities that are controlled and legal.[773] In *Sporting Exchange* the CJEU highlighted the 'detrimental nature of competition in the market',[774] which arises from the fact that 'operators would be led to compete with each other in inventiveness in making what they offer more attractive and, in that way, increasing consumers' expenditure on gaming and the risks of their addiction'.[775] This fact 'may justify a restriction on the activity of economic operators'.[776] The CJEU appears to justify this by reference to the fact that, unlike competition in a traditional market, competition 'between several

[769] ibid, para 30.
[770] Case C-46/08 *Carmen Media* [2010] ECLI:EU:C:2010:505.
[771] Case 212/08 *Zeturf* [2011] ECLI:EU:C:2011:437, para 71.
[772] Ladbrokes para 30 and Case C-347/09 *Dickinger and Ömer* [2011] ECLI:EU:C:2011:582, para 67.
[773] Case C-203/08 *Sporting Exchange* [2010] ECLI:EU:C:2010:307, para 57; Case C-316/07 Markus Stoß [2010] ECLI:EU:C:2010:504, para 82; Case C-212/08 Zeturf [2011] ECLI:EU:C:2011:437, para 42; Case C-347/09 *Dickinger and Ömer* [2011] ECLI:EU:C:2011:582, para 49; Case C-186/11 *Stanleybet* [2013] ECLI:EU:C:2013:33, paras 30 and 45; Case C-156/13 *Digibet* [2014] ECLI:EU:C:2014:1756, para 31.
[774] Case C-203/08 *Sporting Exchange* [2010] ECLI:EU:C:2010:307, para 58.
[775] ibid, para 58.
[776] ibid, para 58.

operators authorised to run the same games of chance'[777] is what leads to more inventive and more attractive offerings.

This whole line of jurisprudence stands in stark contrast with the approach of the CJEU to Member State intervention and competition in the alcoholic beverages market, where restrictions on trade in alcoholic beverages have been held incompatible with the Treaties on the basis that they distort competition – for instance in *Scotch Whisky* the CJEU considered a minimum unit pricing measure to be a 'serious obstacle … to the operation of fair competition in that market'.[778] It could be argued that many alcoholic beverages that are commonly drunk in hazardous ways are extremely similar in their physical properties, and differ only in how inventive producers can be with their branding and marketing efforts.[779] The CJEU has therefore been inconsistent on whether it is desirable or not to discourage competition between free market operators for the purpose of combatting addictions. Since corporate activity and the operation of the free market are important factors of the addictiogenic environment, this inconsistency may also undermine the capacity of Member States to develop a truly holistic approach to addiction governance.

In summary, the EU has less scope to legislate in the field of gambling services in order to discharge its responsibilities for supranational addiction governance. Instead it has been playing a coordinating role, which still discharges responsibility, yet cannot create actual binding standards of protection. This must be achieved by the Member States. Yet the way in which the CJEU has developed its gambling jurisprudence makes this a difficult and somewhat confusing endeavour. Not only has the case law grown to be highly complex, it also appears to be inconsistent with case law developed in relation to other objects of addiction – a fact which does little to encourage behavioral and substance addictions to be addressed holistically

V. Conclusion

In the absence of a specific strategy dedicated to addiction prevention, the EU might at least have ensured that in fields where addiction is a major concern, such as the tobacco, alcohol and gambling fields, some attention was devoted to the problems of addiction, in addition to heavy and hazardous consumption. It appears though, from an analysis of the EU's direct and indirect engagement with

[777] Case C-186/11 *Stanleybet* [2013] ECLI:EU:C:2013:33, para 45.
[778] *Scotch Whisky*, n365 above, para 46.
[779] D Vrontis, 'Strategic assessment: the importance of branding in the European beer market' (1998) 100(2) British Food Journal 76.

addiction issues, that addictive consumption of potentially harmful objects has not been adequately addressed.

The result has been that transnational factors of the addictiogenic environment – such as the marketing strategies of multinational corporations, or the conflict between trade promotion obligations and public health protection obligations – are not being effectively controlled. What is more, the evolution of EU case law at times prevents Member States from discharging their own responsibilities for addiction policy.

This outcome has some important consequences for the overall control of the addictiogenic environment in Europe. Firstly, the absence of EU action on transnational addictiogenic environment factors means that Member States are forced to adopt responsibility for these issues, else they would be left unaddressed. This then leads naturally to transnational factors being dealt with in disparate ways. When Member States' actions are invariably incompatible with the economic objectives of the Union, the resulting case law may then contribute to causing even further problems for the multilevel allocation of responsibility for addiction policy between the Member States and the EU. Second, a lack of action, or weak action, on particular transnational factors of the addictiogenic environment allows those factors to gain a stronger foothold, entrenching the effects of the addictiogenic environment – for instance, multinational corporations, once invited into the policymaking process, are very difficult to dislodge, without a wholesale shift in policymaking approach. Finally, the EU's failure so far to make good on its mainstreaming obligations have made it hard for both the EU and the Member States to prioritise public health concerns over economic concerns. The consequence is that constructing a truly horizontal approach to addiction governance is difficult.

If this situation is left to unfold, then the addictiogenic environment will remain strong in Europe, and millions of cases of preventable addiction will cause high levels of mortality and morbidity. A fresh approach to addressing addiction is needed. Setting out how this fresh approach might be designed is the task of the remaining chapters of this thesis, starting in the next chapter with a discussion of the normative policymaking principles that might inform the design of such renewed strategic action on addiction prevention.

CHAPTER SEVEN – DESIGNING A RENEWED AND MORE INTENSE STRATEGIC APPROACH TO ADDICTION

I. Introduction

This thesis has put forward the case that addiction can best be explained as an adaptation to the experience of social dislocation, and that an addictiogenic environment exists, which promotes, encourages and facilitates the development of addictions. It is normatively acceptable for legal intervention to be applied in order to control the factors of the addictiogenic environment, and the EU could and should contribute to such control at the supranational level in order to support the efforts of the Member States in reducing the currently high prevalence of preventable addictions across Europe. The thesis has also shown that, despite having developed some good building blocks of effective addiction policy, the Member States have not been able to design approaches to addiction policy that address the root causes of addiction in a coordinated way, which makes the best use of available evidence. The thesis has furthermore argued that the EU has, in particular,

failed to support the multilevel approach that is needed in order to address addiction most effectively, failing overall to act on transnational factors of the addictiogenic environment and to make best use of the powers available to it in order to add value to the actions of the Member States.

To summarise this in a different way, EU policymakers are normatively entitled, and legally empowered, to support the Member States in controlling the addictiogenic environment, yet have not engaged well with the responsibilities they owe to the Member States in their efforts to address this important public health and social problem. The result is, to date, an incoherent and only partially evidence-based set of approaches to the addiction phenomenon across Europe, where transnational factors of the addictiogenic environment are left unchecked, and the Member States fail to learn from each other's best practices.

This chapter will argue that in order for a renewed, more intense response to addiction policy to be successful, especially at EU level, addiction policy design must be more closely aligned with the available evidence on the operation of the addictiogenic environment, and the effectiveness of the available legal interventions. Through the analysis of Member State approaches to addiction, it was revealed that addiction policy will be most effective when it is based on three principles – holisticism, horizontality and the multilevel allocation of responsibility. In essence, these principles hold that addiction policy must target the basic root causes of addiction rather than its manifestations, must draw upon all relevant policy fields, and must allocate policy responsibility to the most appropriate level of responsibility. This chapter will argue that in order to ensure that addiction policy at any level, especially the EU level, properly reflects theses ideas, the design of addiction policy must focus on a clearly defined and very specific set of goals, and must be guided by carefully chosen operational paradigms that will ensure that policymakers select the most appropriate and effective legal interventions for the objectives they wish to accomplish. The chapter will therefore set out a template of effective addiction policy design, in which actions are closely aligned with objectives and evidence.

II. Design of effective addiction policy

Policy design, as Howlett et al note, 'involves the deliberate and conscious attempt to define policy goals and connect them to instruments or tools expected to realise those objectives'.[780] Thus, the

[780] M Howlett et al, 'From tools to toolkits in policy design studies: the new design orientation towards policy formulation research' (2015) 43(2) Policy and Politics 291, 291.

starting point for any well-designed strategic approach to addiction is to identify the ultimate objectives of the strategy and then to articulate clear goals that reflect those objectives. The ultimate objective of adopting a renewed and more intense strategic approach to addiction is to exert meaningful control over the factors of the addictiogenic environment. This ultimate objective must however be broken down into more specific policy goals that identify how particular parts of the addictiogenic environment will be dealt with, so that the overall problem of taming the addictiogenic environment becomes more manageable. The analysis below will first argue that articulating the problem to be solved as accurately and precisely as possible will increase the chances that legal intervention to control the factors of the addictiogenic environment will be correctly targeted, and thus ultimately successful.

The analysis will then address the second element of policy design highlighted above – the connection of goals to instruments that are likely to achieve those goals. The clearest of goals cannot be achieved unless they are properly matched to appropriate interventions. Interventions that do not match the goals they pursue are likely to inflame, rather than solve a problem such as addiction. Thus, policymakers should follow a method for ensuring that the most appropriate interventions will be adopted for each goal of an addiction strategy – a policymaking paradigm – which will guide policymakers in interpreting the problem, and in finding solutions that are likely to be most effective in solving it.

A. The importance of clear strategic goals

The process of identifying policy goals for a focussed, strategic approach to controlling the addictiogenic environment is an essential one to get right. Efforts to reinvigorate addiction policy in Europe will only be successful if action is targeted at the right problems.

For EU level addiction policy in particular, setting clear goals for renewed efforts to address transnational factors of the addictiogenic environment will be important to the process of uniting the policy approaches that have developed in different fields of EU public health and social policy. A new strategic approach to addiction at EU level should aim to 'address the perceived shortcomings of previous, more ad hoc, policy regimes',[781] and the success of such an endeavour depends heavily on the establishment of a 'policy domain with coherent policy goals'.[782] Consequently, precise

[781] J Rayner and M Howlett, 'Introduction: Understanding integrated policy strategies and their evolution' (2009) 28 Policy and Society 99, 101.
[782] ibid, 104.

articulation of what the objectives of more intense addiction policy are will be necessary in order to provide a sufficiently well-defined policy domain.

Clearer goals will also give measures adopted within the Strategy a greater chance of withstanding legal challenge. As has previously been highlighted, the proportionality of measures is assessed based on the legitimate objective being pursued. The *Scotch Whisky* decision is an excellent example of unclear goals undermining the defence of a measure designed to improve public health. Although in reality the legitimate objective of minimum unit pricing is to reduce the consumption of high-strength-low-price alcohol by hazardous and harmful drinkers, with the side effect of reducing population consumption generally,[783] these two goals were presented as twin legitimate objectives before the CJEU, leading the CJEU to question the necessity of minimum unit pricing when taxation seemed to offer greater benefits in relation to achieving both a general and a specific objective.[784] The legality of the measure was ultimately put in jeopardy on account of the failure to properly articulate its goals. Thus, articulating the goals of strategic action on addiction in an unambiguous way is crucial for ensuring that any policies adopted in pursuit of them can be defended, should they conflict with free trade norms.

As has been discussed in previous chapters, the addictiogenic environment model suggests that there are three elements in the development of any addiction – the experience of social dislocation, the creation of a pseudo-relationship, and engagement in vocational consumption. In order for any strategic approach to addiction to be successful, it is argued that these three processes must be targeted, in a coherent manner. To successfully target the right problems, clear goals must be articulated that pull together not only existing relevant approaches that might be worth continuing with, but also new courses of action. A clearly articulated goal of strategic action, focussed on one particular element of addiction development, will provide policymakers with 'a statement of key principles that rationalize existing goals and thus constitute the "architecture" of the new policy domain'[785] – the new policy domain in this case being either the prevention of social dislocation, the discouragement of pseudo-relationships, or the removal of vocational consumption opportunities. The ultimate objective connecting this network of policy domains within an overarching addiction strategy is control over and weakening of the addictiogenic environment.

[783] See Opinion of Advocate General Bot delivered on 3 September 2015 in Case C-333/14 *Scotch Whisky Association* [2015] ECLI:EU:C:2015:527, paras 115-120.
[784] *Scotch Whisky*, n 365 above, para 47-48.
[785] Rayner and Howlett, n 781 above, 101.

With the foregoing in mind, one might articulate potential goals of an addiction strategy as follows. The promotion of social dislocation is one element of the addictiogenic environment. If certain factors within an individual's environment promote the development of social dislocation, then it would appear logical to name these factors as problematic, and to target them. Any factor of the environment that causes or leads to the cause of feelings of non-belonging should be targeted, any factor of the environment that causes acute levels of unnecessary stress to individuals, any factors of the environment that results in an individual feeling denigrated or degraded is included, and any factor that causes an individual to under-value themselves. Many of these effects are identifiably and tangibly produced by the design or operation of social institutions, and those institutions should be understood to be the root of the problem. Thus, the goal of addiction strategy in relation to preventing social dislocation from occurring might be articulated as *reforming the design or operation of social institutions to ensure that they do not exclude, acutely stress, denigrate or under-value any individual.*

The encouragement of individuals to begin pseudo-relationships with potential objects of addiction is another element of the addictiogenic environment. Again, where certain factors of an individual's environment encourage such pseudo-relationships, it is logical to identify these factors as problematic. Thus, any factor that raises the acceptability or status of an object of addiction within society should be targeted, any factor that boosts the visibility of that object, any factor that increases the appeal or attractiveness of that object while hiding its harmful features, or any factor that leads to commoditisation of the object. Usually these outcomes are achieved through the promotion of profitably traded objects, though not always – sometimes these effects are the result of government policy itself, policy which promotes economic growth at the expense of the health of the population. Consequently, a further goal of any addiction strategy, with the encouragement of pseudo-relationships in mind, might be articulated as: *preventing actors that have an economic stake in the increased consumption of addictive objects from intentionally or unintentionally making those objects more acceptable, visible, attractive or commodified.*

The facilitation of vocational consumption is the final element of the addictiogenic environment. As with the previous two factors, intervention must target factors of the individual's environment that can be considered problematic in this regard. Consequently, any factor that raises the availability of objects of addiction should be targeted, as must factors that make objects of addiction more accessible, and factors that make such objects more affordable. These outcomes are often the result of government policies that permit economic operators to run long opening hours, allow them to

saturate neighbourhoods with outlets, or allow them to offer cheap deals on addictive objects. In short, if policy allows economic operators to increase access to potential objects of addiction, then increase access they will. Thus, a final goal of any addiction strategy, connected to vocational consumption, might be articulated as: *restricting the ability of economic operators to increase the availability, accessibility and affordability of potential objects of addiction.*

Having discussed the formation of goals of strategic approaches to addiction, the next sub-section considers how interventions might be selected to put these goals into effect, by examining the identification of suitable policymaking paradigms for addiction policy.

D. The importance of well-chosen operational paradigms

In order to ensure that the most effective action is being taken in pursuit of the chosen goals of renewed addiction strategy within Europe, guiding principles are needed that will assist policymakers to consistently identify interventions that match the goals being pursued. Just as NCD interventions in general must 'meet rigorous, evidence-based criteria',[786] so too must interventions that seek to control the factors of the addictiogenic environment. As Marmot suggests, in order to make effective policy, 'a simple prescription would be to review the scientific evidence of what would make a difference, formulate policies, and implement them – evidence based policy making'.[787] Formulating policies from the available evidence though is far more complex than these three basic steps suggest - the analysis below argues that the process of selecting interventions of proven effectiveness that are likely to produce the outcomes sought will be most accurate when guided by the right policy paradigm. First, paradigms and their utility to designing an effective addiction strategy will be explained. Then, one paradigm that would be particularly suitable to guide policy choices on how to control the addictiogenic environment – the paternalism paradigm – will be discussed.

i. The utility of paradigms for connecting goals to action

According to Thomas Kuhn, the first scholar to thoroughly address the nature of a paradigm, paradigms are a way of making sense of and solving the problems that the world presents us with. He described a paradigm as an achievement that comprises two elements. First it is 'sufficiently unprecedented to attract an enduring group of adherents away from competing modes of scientific

[786] Beaglehole et al, n 5 above, 1440.
[787] M Marmot, 'Evidence based policy or policy based evidence' (2004) 328(7445) British Medical Journal 906, 906.

activity'.[788] Second it is 'sufficiently open-ended to leave all sorts of problems for the redefined group of practitioners to resolve'.[789] In other words, a paradigm should constitute a novel way of thinking, which identifies a particular type of problem and how that problem should be dealt with. Some have alternatively summarised paradigms as instructions that help to 'deal with … the research questions [investigators] should ask, and the rules to follow in the interpretation of the results'.[790] Others identify them as conceptual tools that 'guide what problems are deemed acceptable for investigation'[791] and which provide 'an overarching set of theories, methods and commitments'[792] that should be relied on in order to solve that set of problems. Paradigms then, are sets of ideas that identify problems and propose acceptable solutions.

When applied specifically to policymaking, the purpose of paradigms has been described in a number of ways. Campbell defines them as 'assumptions that constrain the cognitive range of useful solutions available to policy makers'.[793] Hall has suggested that paradigms give policy makers a 'framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing'.[794] Capano adds further detail by describing a policy paradigm as 'a coherent series of beliefs about the "things to be done", and about "how" they should be done', which more specifically includes 'the basic, inexorable values that are to dictate policy strategy' and 'the series of cause-and-effect relationships by means of which the participants formulate their general strategy of intervention'.[795] *Policy paradigms* are then, essentially, a 'method for translating thought into action'.[796] Consequently, employing policy paradigms to guide policy choices in the addiction field will help to ensure that the goals of renewed and more intense addiction strategy will be pursued by appropriately targeted interventions.

[788] T Kuhn, *The Structure of Scientific Revolutions* (3rd Ed) (The University of Chicago Press, 1996), 10.
[789] ibid, 10.
[790] J Arndt, 'On Making Marketing Science more Scientific: Role of Orientations, Paradigms, Metaphors, and Puzzle Solving' (1985) 49 Journal of Marketing 11, 11.
[791] J Peel, *Science and Risk Regulation in International Law* (Cambridge University Press 2010), 94.
[792] ibid, 94.
[793] J Campbell, 'Institutional analysis and the role of ideas in political economy' (1998) 27 Theory and Society 377, 385.
[794] P Hall, 'Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain' (1993) 25(3) Comparative Politics 275, 279.
[795] G Capano, 'Administrative traditions and policy change: when policy paradigms matter. The case of Italian administrative reform during the 1990s' (2003) 81(4) Public Administration 781, 783.
[796] L Morton, 'Teaching Creative Problem Solving: A Paradigmatic Approach' (1998) 34 California Western Law Review 375, 380.

A well-chosen paradigm, or set of paradigms, will be able to 'redirect … efforts towards the factors that are responsible'[797] for a strong addictiogenic environment, and to 'increase efficiency by guarding against wayward tangents'[798] that might be thrown up by forces such as corporate lobbying, which seek to distract policymakers from selecting interventions that are likely to exert meaningful control over the addictiogenic environment. When it comes specifically to the unequal manner in which the addictiogenic environment affects populations on account of widespread social inequalities, the right paradigms can provide 'an explicit framework that attempts to explain health disparities across populations',[799] with action then being targeted at the root of this explanation. In sum, basing the selection of addiction interventions upon well-chosen policy paradigms will allow policymakers to work out what the most effective interventions will be for controlling the factors of the addictiogenic environment.

For policymaking at the EU level in particular, in addition to guiding policymakers towards the most evidentially effective solutions, the right paradigm can bring coherency to attempts to create a strategic approach to a certain policy issue. Coherency occurs when 'policies pursued by different parts of the EU machine [are] consistent with each other'.[800] This calls for some method of ensuring that 'different initiatives buttress the same goals'.[801] When there are multiple facets to solving a policy problem, such as there are when tackling the factors of the addictiogenic environment, approaching each facet of the problem through the same or similar paradigmatic process will help to ensure that the same or similar 'ideational resources or patterns of thought'[802] are drawn upon, therefore leading to a set of harmonious interventions. Adopting a coherent approach to addiction policy is not just an advantage in terms of ensuring that interventions will not contradict each other – as Hall points out, 'policymakers are likely to be in a stronger position to resist pressure from societal interests when they are armed with a coherent policy paradigm. If it does not dictate the optimal course for policy, at least it provides a set of criteria for resisting some societal demands while accepting others'.[803] Thus, choosing the correct paradigms to ensure a coherent approach to

[797] R Scribner, 'Editorial: Paradox as Paradigm – The Health Outcomes of Mexican Americans' (1996) 86(3) American Journal of Public Health 303, 304.
[798] Morton, n 796 above, 380.
[799] J Corburn, 'Confronting the Challenges in Reconnecting Urban Planning and Public Health' (2004) 94(4) American Journal of Public Health 541, 541.
[800] G Olsen, 'Coherence, consistency and political will in foreign policy: The European Union's policy towards Africa' (2008) 9(2) Perspectives on European Politics and Society 157, 160.
[801] ibid, 160.
[802] C Boswell et al, 'The role of narratives in migration policy making: a research framework' (2010) 13 British Journal of Politics and International Relations 1, 2.
[803] Hall, n 794 above, 290.

addiction policy is not only important for the targeting of interventions, but for resisting the organised efforts of the addiction industries to influence policy change.

However, care must be taken when choosing paradigms, since paradigms are not solely used to direct policymakers towards a set of solutions that are evidentially effective – they can also be employed to channel policymakers towards solutions that are the most politically feasible. Although basing addiction interventions upon evidence is crucial, evidence is not the only factor that must be considered in selecting interventions, since policymaking is 'driven by ideology, value judgements, financial stringency, economic theory, political expediency, and intellectual fashion',[804] as well as science and epidemiology. Since paradigms are more than just objective theories, but rather are subjective problem solving blueprints that 'are not value-free and neutral… [but rather] may be viewed as social constructions',[805] they can be employed by stakeholders wishing to push their own agenda in order to 'target the values of the policymakers'.[806] Similarly, if policymakers themselves approach an issue with a closed view of what they want to hear, there is a risk that the available evidence on the addictiogenic environment will not be translated into effective policy. As Marmot notes, 'although it is understandable that governments should do what they want rather than what a group of scientists suggests they should do, it means that the model of evidence based policy … is something of a parody'.[807] Effective control of the addictiogenic environment calls for several actions that are not politically appealing. Thus, care must be taken to resist following an addiction policy paradigm that will point to solutions that are politically easy, rather than ones that are evidentially effective.

Having discussed the nature of paradigms, and the reasons why addiction policymakers should allow their selection of interventions to be guided by paradigms, the analysis below will argue that following a paternalist paradigm in the making of addiction policy will lead towards legal interventions that will be most evidentially effective in controlling the addictiogenic environment.

ii. The paternalist paradigm

This section argues that approaching addiction policy through a paternalist paradigm is one way in which a renewed and more intense strategic approach to addiction policy could be guided towards

[804] N Black, 'Evidence based policy: proceed with care' (2001) 323 British Medical Journal 275, 276.
[805] J Arndt, 'On Making Marketing Science more Scientific: Role of Orientations, Paradigms, Metaphors, and Puzzle Solving' (1985) 49 Journal of Marketing 11, 11.
[806] Black, n 804 above, 277.
[807] M Marmot, 'Evidence based policy or policy based evidence' (2004) 328(7445) British Medical Journal 906, 907.

strong interventions that are likely to provide effective, targeted control over the factors of the addictiogenic environment.

Paternalism is an approach to policymaking that has traditionally been defined as 'interference with the liberty of another for the purposes of promoting some good or preventing some harm, for the sake of the other person'.[808] It is possible, however, to understand the concept in a more refined way. Paternalism, in essence, describes a process where a public authority exercises power over individuals in order to substitute the preferences of the individual for the preferences of the government. The paternalist paradigm is essentially the idea that adopting legal interventions that replace individual preferences with state preferences will neutralise the profoundly unfair influence of many factors of the addictiogenic environment. What follows is an argument that a renewed approach to addiction, which seeks to more strategically and intensely control the factors of the addictiogenic environment, based on the available evidence, should be guided by a paternalist paradigm.

The idea that states should intervene paternalistically in order to protect citizens has been present in the academic literature for a while. Discussions of public health paternalism date back to the mid-1980s,[809] yet it has only been in the first decade of the 21st Century that discussions on the legitimacy of public health paternalism have begun to burgeon. This is because the application of paternalist ideas to solve public health problems is still a relatively taboo subject - as Gostin has remarked, 'few people are willing to concede that their beliefs or actions are paternalistic; seldom will one see a frank defence of paternalism'.[810] This is perhaps because there is still perceived to be a 'dichotomous … choice between, on the one hand, upholding individual autonomy and, on the other, intervening paternalistically'.[811] Autonomy is still viewed as a guiding ethical principle of public health, despite the fact that, as explained at various points in this chapter, few choices made within a strong addictiogenic environment are truly autonomous.

It will be argued below that paternalism should not be seen as an unwarranted inference by government, but as action that makes good upon a government's obligations to protect its citizens when such protection would be just and equitable to afford. The addictiogenic environment exerts a pervasive and unfair influence upon individuals, who have little chance of controlling it themselves.

[808] Merry, n 257 above, 2.
[809] For example, see: Beauchamp, n 280 above.
[810] Gostin, n 388 above, 52.
[811] A Ogus, 'The paradoxes of legal paternalism and how to resolve them' (2010) 30(1) Legal Studies 61, 68.

If populations are to become healthier through the absence of a strong addictiogenic environment, public action is required to exert socially just control on behalf of populations.

Selecting a paternalism paradigm to guide addiction policy is supported by the fact that consumers are constantly being manipulated by powerful actors, a lot of the time with negative health consequences. As discussed previously in this thesis in relation to the ethical principle of autonomy, it is rare that individuals are in the position to make decisions that are completely uninfluenced by external forces. Building on this analysis, the reasons why individuals are so susceptible to the influence of external environmental forces might be explored in more detail. First, in the modern marketplace, individuals are exposed to 'consumer hyperchoice',[812] a situation which leads to 'a diminishment of mindfulness or attentional control'[813] due to the fact that 'consumers have finite limits to absorb and process information during any given unit of time'.[814] In order to cope with information overload, there is 'compelling evidence that consumers use heuristic decision rules'[815] to narrow down their options. Heuristic decision making involves 'develop[ing] rules of thumb and rely[ing] on ad hoc perceptions, emotions, accumulated memory, and loose associations'.[816] This type of decision making, while improving cognitive efficiency, markedly decreases choice optimality. For example, 'one strategy for estimating unknown quantities is to start with information one does know and then adjust until an acceptable value is reached'.[817] This anchoring heuristic enables rapid estimation of (on the whole) numerical value, but 'adjustments are typically insufficient'[818] as 'different starting points yield different estimates, which are biased toward the initial values'.[819] Another example is the availability heuristic – consumers 'assess the magnitude of risks by assessing

[812] M Solomon, *Consumer Behavior: Buying, Having and Being*, 9th Ed (New Jersey: Pearson, 2009) 332.
[813] D Mick et al., 'Choose, Choose, Choose, Choose, Choose, Choose, Choose: Emerging and Prospective Research on the Deleterious Effects of Living in Consumer Hyperchoice' (2004) 52 Journal of Business Ethics 207, 209.
[814] N Malhotra, 'Information load and consumer decision making' (1982) 8(4) Journal of Consumer Research 419, 419. These ideas on information overload can trace their roots back to Herbert Simon's theory of bounded rationality: H Simon, 'A behavioural model of rational choice' (1955) 69(1) Quarterly Journal of Economics 99.
[815] J Hauser, 'Consideration-Set Heuristics' (MIT, 2010) available at http://web.mit.edu/hauser/www/Hauser%20Articles%205.3.12/Hauser%20Consideration%20Heuristics%20JBR%202011.pdf (accessed 8 April 2014), 1.
[816] J Rachlinski, 'The uncertain psychological case for paternalism' (2003) 97(3) Northwestern University Law Review 1165, 1168.
[817] N Epley and T Gilovich, 'The anchoring-and-adjustment heuristic: why the adjustments are insufficient' (2006) 17(4) Psychological Science 311, 311.
[818] A Tversky and D Kahneman, 'Judgement under Uncertainty: Heuristics and Biases' (1974) 185(4157) Science 1124, 1128.
[819] ibid.

whether examples of harm can readily be brought to mind'.[820] Although this is cognitively powerful, it is subject to large bias, as 'the easier it is to retrieve examples of an event, the higher the estimated likelihood of occurrence',[821] and is furthermore 'influenced by the degree to which information is emotionally compelling and vivid'.[822]

The fact that individuals regularly employ heuristic decision making is routinely exploited by economic operators. As Hansen and Kysar note:

> 'the presence of unyielding cognitive biases makes individual decision makers susceptible to manipulation by those able to influence the context in which decisions are made … market outcomes frequently will be heavily influenced, if not determined, by the ability of one actor to control the format of information, the presentation of choices, and, in general, the setting within which market transactions occur. Once one accepts that individuals systematically behave in nonrational ways, it follows from an economic perspective that others will exploit those tendencies for gain'.[823]

Thus, individuals often make consumption decisions that they have been pushed towards. For example, 'it is often possible to frame a given decision problem in more than one way',[824] with the result that 'seemingly inconsequential changes in the formulation of choice problems cause[s] significant shifts of preference'.[825] In situations of consumer uncertainty, 'advertising rhetoric is aimed at reminding us of what we are supposed to know (or rather, of what the company wants us to know)'.[826] Careful design allows marketers to match products very closely to the emotional and psychological needs of different consumer groups, making it more likely that such groups will choose the products being targeted at them.[827] These are mere examples of the vast array of market manipulation performed by corporations that produce potential objects of addiction, in order to persuade consumers of the attractiveness of their products, and discount their risks.

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[820] C Sunstein, 'The Availability Heuristic, Intuitive Cost-Benefit Analysis, and Climate Change' (2005) John M. Olin Program in Law and Economics Working Paper No. 263, 5.
[821] E Peters et al, 'A heuristics approach to understanding cancer risk perception: contributions from judgment and decision-making research' (2006) 31(1) Annals of Behavioral Medicine 45, 47.
[822] ibid, 48.
[823] Hansen and Kysar, n 267 above, 635.
[824] Tversky and Kahneman, n 260 above, 453.
[825] ibid, 457.
[826] F Cochoy, 'Is the modern consumer a Buridan's donkey? Product packaging and consumer choice' in K Ekstrom and H Brembeck (eds), *Elusive Consumption* (Berg 2004), 208.
[827] See for example: B Le Cook et al, 'One size does not fit all: how the tobacco industry has altered cigarette design to target consumer groups with specific psychological and psychosocial needs' (2003) 98 (11) Addiction 1547.

From the perspective of a government that aspires to the pursuit of social justice, allowing economic actors to push individuals in vulnerable positions towards consumption decisions that will harm them is unfair. Furthermore, from the perspective of a government bound by obligations to provide individuals with conditions in which they can avoid the development of addiction, neglecting to control the actions of economic actors who would seek to take advantage of behavioural biases and vulnerabilities is a violation of those obligations. The obligations placed on States (and normative responsibilities placed upon the EU through Article 35 CFREU) require the pursuit of 'positive measures that enable and assist individuals and communities to enjoy the right to health',[828] and an effort to '*fulfil (provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal'.[829]

Thus, where economic actors seek to exert power over individuals so as to push them towards particular consumption decisions, or place them in situations where their vulnerabilities will incline them towards certain consumption decisions, public authorities should take responsibility for exerting their own powers to place individuals back into situations where the influence of those economic actors is negated. As Berman notes, individuals often 'do not [and cannot] appreciate the degree to which their decisions are products of their environments',[830] and thus the state should, in discharging its legal and ethical obligations to protect the health of its citizens, replace individual preferences that are the product of malicious environmental influence with preferences that seek to return agency to individuals.

This social justice perspective on paternalism, 'recognizes that there are basic health protections which are fair, and which are in everyone's best interests to take together'.[831] As Wiley argues, it is time to 'replace the "nanny state" framing with a more positive vision of community action'.[832] Some have argued that it is 'not even accurate to think of public health paternalism as directed at the individual at all, but instead directed towards overall societal welfare',[833] meaning that a choice to substitute preferences 'acts at the level of practices and not at the level of individual behaviour'.[834]

[828] General Comment 14, n 196 above, para 37.
[829] ibid.
[830] M Berman, 'From health care reform to public health reform' (2011) 39(3) Journal of Law, Medicine and Ethics 328, 332.
[831] Gostin and Gostin, n 266 above, 218.
[832] Wiley et al, n 172 above, 90.
[833] Gostin and Gostin, n 266 above, 217.
[834] ibid.

In any event, a paternalist approach to policymaking encapsulates the proposition that where societal conditions unfairly influence the lives of individuals, the response of the state should be to intervene to neutralise their effects in order to protect populations. This reflects the justifications for intervention presented earlier in this thesis. It is argued that this understanding of paternalism should be adopted and applied as a guiding paradigmatic idea to the selection of legal interventions that will comprise a renewed strategic approach to controlling the factors of the addictiogenic environment.

In summary, the paternalist paradigm could be used to ensure that a renewed strategic approach to addiction selects effective and equitable interventions. Policymakers should aim to adopt policies that replace individual preferences with state preferences at a population level, wherever individual preferences are likely to be the product of strong, unfair environmental influences upon their behaviour. A paternalist approach would therefore connect goals such as those outlined above, which seek to reform, prevent and restrict, to action that would indeed reform, prevent and restrict, by prompting policymakers to assume that unfair influence of any character must be negated. The final section of this chapter will briefly illustrate how this paradigmatic thinking could guide EU policymakers towards interventions that, within the limits of the EU's competence, are effective, evidence based, and fit the best practice principles for addiction policy discussed in earlier chapters.

III. Interventions that EU policymakers could undertake

Having discussed how the selection of legal interventions to control the addictiogenic environment should be guided by the careful articulation of strategic goals and appropriate policy paradigms, this chapter moves on to consider which specific interventions EU policymakers might consider pursuing in order to address transnational factors of the addictiogenic environment and add value to the addiction policy efforts of the Member States.

The analysis below will consider on three policy fields - fiscal policy, social exclusion policy and communications policy – and will discuss an example intervention that might be taken. In doing so, this section hopes to show that by focusing on clearly defined problems, and by committing to policymaking ideas that prompt a more intense yet equitable level of action, the EU can contribute meaningfully to controlling transnational factors of the addictiogenic environment. It will also show how such design can draw upon the principles of holisticism, horizontality and multilevel responsibility.

A. Interventions in the fiscal field

The first policy field that could be drawn upon by EU legislators seeking to impose greater control over the addictiogenic environment is fiscal policy. Fiscal interventions in the context of public health involve utilising rates of taxation on products, minimum price floors, financial incentives, and other policies relating to the price of goods. Due to the link between the affordability of products and consumption habits, particularly amongst the heaviest consumers, [835] fiscal policies have great 'ability to change people's consumption behaviours'.[836] By making addictive objects less affordable, they are less likely to be seen as everyday consumption items, and are less likely to be available to individuals on a regular basis. Although an increase in tax or a minimum price might appear to increase government and industry revenues, in actual fact the reductions in consumption that results from increased taxation are such as to produce an overall fall in government revenue.

A particular factor of the addictiogenic environment that could be addressed through fiscal interventions is the prevalence of price promotion on potential objects of addiction. Price promotion can elicit positive emotional feelings in consumers, who by taking advantage of a price promotion can feel that they have themselves engineered a discount,[837] as well making purchasing the desired products cheaper. Price promotion is therefore a key factor facilitating vocational consumption of objects of addiction. Consequently, it is a tactic relied upon by manufacturers and retailers in order to 'cultivate long-term relationships with individual consumers'.[838] A good example in the context of alcoholic beverages is the proliferation of "happy-hours" – specific periods of time in which alcoholic beverages are heavily discounted – since during these times, drinkers are induced to drink far more (and thus spend more) than they would otherwise have done due to the low prices and appearance of value for money.[839] They also contribute to a '"wet" environment, in which alcohol is prominent and easily accessible'.[840] Thus, this is a factor that fits squarely within the parameters of an economic operator increasing the accessibility and affordability of an object of addiction, and thus falls within the scope of the third goal outlined above. Since consumers are unaware most of the time of the

[835] F Chaloupka et al, 'The Effects of Price on Alcohol Consumption and Alcohol Related Problems' (2002) 26(1) Alcohol Research and Health 22.
[836] Sassi et al, n 143 above, 95.
[837] R Schindler, 'The excitement of getting a bargain: some hypotheses concerning the origins and effects of smart-shopper feelings' (1989) 16 Advances in Consumer Research 447.
[838] L Henriksen, 'Comprehensive tobacco marketing restrictions: promotion, packaging, price and place' (2012) 21 Tobacco Control 147, 150.
[839] See the experimental study on happy hours conducted by Babor and colleagues: T Babor et al, 'Experimental analysis of the 'happy hour': Effects of purchase price on alcohol consumption' (1978) 58(1) Psychopharmacology 35.
[840] M Kuo, 'The marketing of alcohol to college students: The role of low prices and special promotions' (2003) 25 American Journal of Preventive Medicine 204, 204.

purpose of price promotions, or that they may consume more than they might have done in the absence of the promotion, price promotions also constitute an unfair environmental influence, and therefore also fall within the scope of the type of problem identified by the paternalist paradigm. An intervention that replaces the preference of the individual with preferences that promote population health is therefore required.

The EU could, relying on the broad regulatory scope of Article 114, legitimately adopt harmonised standards setting minimum selling prices for objects of addiction. Member States have already begun to adopt minimum pricing policies for objects of addiction,[841] so the potential for barriers to arise to the operation of the internal market of goods and services has already been established, in line with the *Tobacco Advertising* rulings.[842] This provides a sufficient link to the operation of the internal market to permit the use of Article 114 TFEU. Furthermore, The CJEU has confirmed that minimum pricing raises issues of cross-border trade, yet may only be compatible with EU law so long as they pursue targeted objectives and are supported by evidence.[843] A growing evidence base has indeed been accumulating to support the efficacy for minimum pricing measures in relation to alcohol, which aims to reduce the proliferation of cheap, high strength alcohol within society,[844] and which would serve to prevent economic operators from using artificially low selling prices to attract consumers. Consequently, a minimum pricing intervention would seek to counter unfair environmental influences, it would fall within the limits of the EU's legal powers, and it reflects accumulating evidence.

The idea of minimum unit pricing, which has already gained support in the alcohol field, could be applied holistically to create harmonised standards for a range of common objects of addiction, on the basis that the basic function of any price promotion, whatever the product or service, is to allow consumers to temporarily purchase a greater quantity than normal market conditions would normally allow. For example: a minimum stake could be placed on games of chance to reduce the

[841] For example, the Scottish minimum pricing policy, on which see: O Bartlett, 'Distilling prospects: reflections on the proportionality of minimum unit pricing under EU law' [2014] 1 European Journal of Risk Regulation 73. Also, the recently proposed Irish policy on minimum pricing, on which see: Institute of Alcohol Studies 'Minimum unit pricing comes to Ireland' (January 2016) available online at http://www.ias.org.uk/What-we-do/Alcohol-Alert/January-2016/Minimum-unit-pricing-comes-to-Ireland.aspx (last accessed 15 July 2016).
[842] 'Admittedly, as is clear from the case-law of the Court, the harmonisation of laws may legitimately aim to prevent the emergence of future obstacles to trade resulting from heterogeneous development of national laws': Case C-376/98 *Germany v Parliament and Council* [2000] ECLI:EU:C:2000:544, para 27.
[843] *Scotch Whisky*, n 365 above.
[844] Stockwell et al, n 152 above.

proliferation of 'first bet free' promotions often run by gambling operators to entice consumer;[845] minimum prices per gram of could be imposed to reduce the appeal of hyper-palatable foodstuffs;[846] and minimum prices per gram of nicotine in a tobacco product could be imposed to reduce the appeal for smokers of simply switching existing consumption of nicotine to considerably cheaper electronic cigarettes,[847] thereby encouraging actual smoking cessation rather than smoking substitution.[848] Such interventions will fit naturally within a paternalist paradigm – while individuals might prefer to access addictive objects very cheaply, consumers have very little knowledge of the way in which the terms of their engagement with objects of addiction are heavily manipulated by price promotions.[849]

B. Interventions in social exclusion field

Social policies represent another essential policy field for an EU Addiction Strategy to engage with. Social policy can be understood as an effort to ensure that basic human needs are met, in order to enable the fulfilment of various secondary needs that are considered necessary for human existence above a minimum threshold.[850] Doyal and Gough identify physical health and autonomy as the two primary categories of basic human need,[851] and further research identifies the building of social relationships and social integration as an important human need that is powerfully connected to physical and mental health.[852] Thus, promoting psychosocial integration for the purposes of reducing

[845] Offering free bets is designed to maximise the time spent gambling, and decrease the apparent risk of the initial engagement. See: N Hing et al, 'Do advertising and promotions for online gambling increase gambling consumption? An exploratory study' (2014) 14(3) International Gambling Studies 394.

[846] The sugar tax recently proposed in the UK has been criticised for discriminating between different sugar containing products – setting a minimum price that a gram of sugar could be sold at would appear to overcome these criticisms.

[847] Evidence on the price of e-cigarettes compared to traditional cigarettes presented in: J-F Etter and C Bullen, 'Electronic cigarette: users profile, utilization, satisfaction and perceived efficacy' (2011) 106(11) Addiction 2017.

[848] R Grana, 'A longitudinal analysis of electronic cigarette use and smoking cessation' (2014) 174(5) Journal of the American Medical Association Internal Medicine 812.

[849] For example, price promotions artificially increase consumers' enjoyment of products: L Lee and C Tsai, 'How price promotions influence postpurchase consumption experience over time' (2014) 40(5) Journal of Consumer Research 943, 954. The faming of prices influences consumer perceptions of value: P Darke and C Chung, 'Effects of pricing and promotion on consumer perceptions: it depends on how you frame it' (2005) 81(1) Journal of Retailing 35. Furthermore, the effect of price cues on behaviour can be reliably predicted and utilised: D Lichtenstein et al, 'Price perceptions and consumer shopping behaviour: a field study' (1993) 30(2) Journal of Marketing Research 234.

[850] For an overview of how social policy can be understood to be directed at meeting human need, see K Blakemore and L Warwick-Booth, *Social Policy: An Introduction* (Maidenhead: Open University press, 2013), 31; and for an identification and analysis of specific human needs, see: L Doyal and I Gough, *A theory of human need* (New York: Palgrave Macmillan, 1991).

[851] Doyal and Gough, ibid.

[852] L Berkman, 'From social integration to health: Durkheim in the new millennium' (2000) 51(6) Social Science and Medicine 843.

the strength of the addictiogenic environment is an activity that falls squarely within the remit of social policy. Another way of expressing the link between social policy and addiction prevention is through the role of social policy in building social capital – 'connections among individuals, within families, friendship networks, businesses and communities'.[853] The more social capital building that the state can encourage through policy, the more opportunities it gives citizens for building a cushion of psychosocial integration that will protect them from the experience of negative affect.

If psychosocial integration can be understood as 'a profound interdependence between individual and society that … reconciles people's vital needs for social belonging with their equally vital needs for individual autonomy and achievement',[854] then one likely place where the interface between individual and society could fail to encourage psychosocial integration is the provision of housing support to foreign nationals. The way in which law provides for housing support to foreign nationals can be discriminatory towards those persons,[855] can actively dissuade them from settling in certain areas,[856] or in some situations can conversely even lead to the perception that an unfair advantage is being conferred and to subsequent vilification of foreign nationals.[857] Discrimination or other poor treatment of immigrants in the housing support system has been found to lead to negative social consequences and the generation of negative affect,[858] potentially contributing to the breakdown of psychosocial integration. Targeting the elimination of discrimination within housing support services therefore fits well with the first goal outlined above, and would constitute the elimination of an unfair environmental influence, in line with paternalist paradigmatic thinking.

Due to the role of EU citizenship in facilitating the movement of persons with a view to settling in another Member State, the EU arguably has a responsibility to encourage its Member States to re-organise certain aspects of housing support policies so as to provide increased opportunities for the psychosocial integration of those who move between Member States. This responsibility could plausibly be discharged through the revival of an OMC-type process – undertaken under the competence provided by Article 153 TFEU – that could potentially focus on preventing the erosion of

[853] C Muntaner, et al, 'Social capital and the third way in public health' (2000) 10(2) Critical Public Health 107, 108.
[854] Alexander, n 75 above, 58.
[855] J Rutter and M Latorre, *Social housing allocation and immigrant communities* (Manchester: Equality and Human Rights Commission 2009), 36.
[856] S Münch, '"It's all in the mix": constructing ethnic segregation as a social problem in Germany' (2009) 24 Journal of Housing and the Built Environment 441.
[857] D Robinson, 'New immigrants and migrants in social housing in Britain: discursive themes and lived realities' (2010) 38(1) Policy and Politics 57.
[858] See for example: J Yinger, 'Housing discrimination is still worth worrying about' (1998) 9(4) Housing Policy Debate 893.

psychosocial integration. While OMC process may not have achieved their potential so far, they offer one advantage that would be valuable to addiction governance in particular, making it worth the effort to minimise disadvantages of the process. OMC processes offer a forum to facilitate multilevel governance, in which 'each level contributes its distinctive expertise and resources to tackling common problems cutting across jurisdictions'.[859] When considering a factor of the addictiogenic environment such as housing support discrimination against migrants, the way in which a psychosocial integration OMC process could encourage discussion of common objectives (but not necessarily common actions) helps to link action both upwards to core EU values and downwards to various national objectives.[860] Thus, a psychosocial integration OMC process that encompassed a discussion of housing support discrimination may encourage better diffusion of the idea of social citizenship of the EU[861] into how Member States treat foreign nationals who seek social support, while allowing the Member States to take action that is consistent with their own social systems. It is therefore worth considering how OMC processes might be utilised in renewed strategic action on addiction at EU level.

C. Interventions in in the communications field.

Communications policy is another field of policymaking that an EU Addiction Strategy should draw from. The phenomenon of communication is 'at the heart of who we are as human beings. It is our way of exchanging information; it also signifies our symbolic capability'.[862] Given the importance of psychosocial integration as discussed above, the ability or lack of ability to communicate in order to forge social bonds is crucial to the development of an addiction. The ability to simulate these bonds is *also* crucial to the development of an addiction – as Alexander again explains, when an individual is suffering social dislocation (a lack of psychosocial integration) they seek to alleviate this though adaptation to a different type of life, one of addiction. Human beings seek social connections, and depend on this for identity and social belonging.[863] In the absence of the opportunity to forge such connections, humans who cannot bear the painful consequence of dislocation will naturally attempt to search for 'substitutes for psychosocial integration'[864] – the pseudo-relationship. As has been explored, pseudo-relationships can potentially be formed with anything that has the capacity to sustain such a phenomenon, such as an object of addiction. Boosting the communicative capacity of

[859] Zeitlin, n 434 above, 220.
[860] ibid, 221.
[861] M Dougan and E Spaventa, '"Wish you weren't here…" New models of social solidarity in the European Union' in M Dougand and E Spaventa (eds) *Social Welfare and EU law* (Oxford: Hart 2005), 183.
[862] R Rimal and M Lapinski, 'Why health communication is important in public health' (2009) 87(4) Bulletin of theWorld Health Organizsation 247, 247.
[863] B Alexander, n 75 above, 58.
[864] ibid, 62.

an object of addiction, usually through advertising, sponsorship, branding and product placement,[865] increases the capacity of that object to sustain a pseudo-relationship, and thus the likelihood that addictions to that object will be developed by individuals experiencing social dislocation.

Relating this to increased appeal and acceptability, a good example of the above can be drawn from the marketing practices of multinational producers of lager. Take for example, the brand Fosters, brewed by multinational beer producer Heineken. The marketing history of Fosters is replete with examples of its producers attempting to enhance the emotional appeal of what is already a psychoactive substance. Fosters has traditionally been promoted with an advertising campaign depicting an 'agony uncle' phone-in situation, depicting two males consuming Fosters and offering light-hearted advice to worried male callers. This is designed to associate the lager in the viewer's mind with comfort, security, and dependability, and the strapline included with the advertisement reflects this – 'Good Call'. Although the campaign is now being dropped after six years, due to Heineken's desire to move the brand away from accusations of sexism,[866] it is unsurprising that during the height of the campaign the Foster's brand director said that the adverts were 'universally loved by our consumer and levels of consumer engagement and brand reputation have soared during the campaign'.[867] Fosters have complemented this campaign with numerous sponsorship agreements. Sponsorship is a 'large and powerful part of alcohol promotion … raising brand awareness, creating brand attitudes and building emotional connections with consumers'.[868] Despite this though, there is no restriction placed on alcohol sponsorship at EU level by the Audiovisual Media Services Directive.[869] This has allowed Foster's to associate their brand with emotionally charged activities such as sport[870] and comedy.[871] The ability of producers of potentially addictive

[865] E Feighery et al, 'Seeing, wanting, owning: the relationship between receptivity to tobacco marketing and smoking susceptibility in young people' (1998) 7 Tobacco Control 123; L Henriksen et al, 'Receptivity to Alcohol Marketing Predicts Initiation of Alcohol Use (2008) 42(1) Journal of Adolescent Health 28.

[866] M Sweney, 'Foster's to end Brad and Dan ads in move away from 'laddish campaigns' (The *Guardian,* 15 May 2015) available at http://www.theguardian.com/media/2015/may/15/fosters-to-end-brad-and-dan-ads-in-move-away-from-laddish-campaigns (last accessed 3 December 2015).

[867] A Haggerty, 'Good Call – Foster's 125th anniversary campaign set to launch' (*The Drum*, 8 February 2013) available online at http://www.thedrum.com/news/2013/02/08/good-call-fosters-125th-anniversary-campaign-set-launch (last accessed 3 December 2015).

[868] G Hastings et al, 'Failure of self regulation of UK alcohol advertising' (2010) 340 British Medical Journal b5650.

[869] Article 10 deals with sponsorship and makes no mention of alcohol, despite placing a ban on tobacco sponsorship: Directive 2010/13/EU on the coordination of certain provisions laid down by law, regulation or administrative action in Member States concerning the provision of audiovisual media services [2010] OJ L 95/1, 15.4.2010.

[870] Foster's sponsored the highly image-focussed sport of Formula One for twenty years: 'Foster's announces end to F1 sponsorship' (*Pitpass*, 11 April 2006) available online at http://www.pitpass.com/27686/Fosters-announces-end-to-F1-sponsorship (last accessed 3 December 2015).

substances to promote their brands through association with emotive activates, participation in which facilitate the creation of emotional bonds, falls within the scope of the second goal outlined above.

As has been identified multiple times throughout this thesis, corporate actors that pursue strategies to enhance the emotional appeal of their products are mostly multinationals that operate at transnational levels. Action at the EU level is therefore necessary to counter these strategies. Not only has the EU already engaged in transnational advertising regulation in the past in the tobacco field, but it has the mandate to do so in all three of the focus fields of tobacco, alcohol and gambling reviewed previously. There is very little reason, besides persistent political opposition, why the EU should not take responsibility for further action in controlling the commercial communications of addiction industries, particular in the field of sponsorship, in which some Member States have had their rules challenged on grounds that they are internal market obstacles.[872]

The EU could implement a harmonised prohibition on sponsorship by producers of addictive objects, again using the legal basis provided by Article 114 TFEU. Sponsorship is a particularly subtle and powerful method of enhancing the emotional capacity of objects of addiction to sustain pseudo-relationships. Sponsorship of cultural or sporting events by alcohol, unhealthy food or gambling brands (tobacco sponsorship now being prohibited under EU law) aims, by industry's own admission, to create an emotional bond between the individual and the product, relying on the already existing emotional bond between the individual and the event sponsored.[873] Even more subtly, sponsorship by addiction industries attempts to weave addictive object brands into the fabric of everyday life in order to normalise their product,[874] and targets activities that are especially popular with young people, such as sports, in order to recruit individuals early.[875] Consumers in vulnerable positions have little power to resist the formation of such bonds, and have little awareness that it is happening. Harmonised sponsorship bans would, following a paternalist paradigm, remove the option for individuals to receive communications from producers of addictive objects, and would remove the preference of corporations to communicate through this medium, with the objective of

[871] Foster's has recently signed a new deal to sponsor Channel 4 comedy shows: R Black 'Channel 4 deal a "new breed of sponsorship" for Foster's' (*The Publican's Morning Advertiser*, 4 February 2015) available online at http://www.morningadvertiser.co.uk/Drinks/Beer/Foster-s-sponsors-comedy-on-Channel-4 (last accessed 3 December 2015).
[872] *Commission v France (loi evin)*, n 696 above.

[873] Hastings, n 119 above.
[874] Casswell, n 118 above.
[875] Maher, n 119 above.

replacing these preferences with a transparent communication environment, through which consumers are able to more clearly see the commercial intent of corporations.

V. Conclusion

This chapter has endeavoured to argue that clearly articulated goas that are targeted at the most important issues presented by the addictiogenic environment, and appropriate paradigms that help policymakers to find the most effective actions for pursuit of those goals, are essential in the design of a strategic approach to addiction. An array of different interventions and variations of these interventions might be selected for inclusion in an addiction strategy, depending on what is deemed most appropriate in different regions of Europe – but whatever content is chosen to populate an addiction strategy, at the very least it should explicitly outline how the three elements of the addictiogenic environment are to be targeted, and should ensure that appropriate, evidence backed interventions are selected to realise each of these goals. Following an appropriate policy paradigm in selecting interventions, such as the paternalist paradigm, will help to ensure that interventions linked to one goal will be coherent with interventions linked to any other goal, within the broader strategy. Ultimately, designers of an addiction strategy must keep in mind that the overarching purpose of such a policy endeavour is to weaken the addictiogenic environment, and that all elements of the strategy must have this at least in common.

The design blueprints suggested by this chapter could be followed by any public authority that seeks to address addiction in a more intense and strategic manner. It would seem most logical that the authorities best placed to drive forward renewed effort on addiction prevention in Europe would be the EU Member States, based on many factors that have been raised previously – their commitments at WHO level to increased NCD action, the societal differences between countries which mean that a completely harmonised European solution to addiction would probably not be effective in some countries, and the fact that as the middle level of public authority between the subnational and the supranational they would be best placed to see how responsibility might be divided. What is clear though is that Member States of the EU cannot, and should not, construct strategic approaches to addiction alone. The EU itself has a crucial role to play, not only in contributing interventions when the factor of the addictiogenic environment in question is transnational and thus should be addressed at transnational level, but in helping the Member States to coordinate with each other when constructing their own strategies – for example to ensure that when allocating responsibilities across multiple levels, the same responsibilities are allocated to the EU in each strategy.

The design of addiction strategies does not, however, take place in a vacuum. Strategies and interventions that might be theoretically and legally possible may attract substantial opposition. The final chapter of this thesis is therefore will therefore analyse the challenges that will be faced in implementing a more intense approach to addiction policy.

CHAPTER EIGHT – CHALLENGES OF A RENEWED APPROACH TO ADDICTION POLICY

I. Introduction

Designing effective addiction interventions is only half the story. Well-designed interventions must be steered through the policymaking process in order to actually get to the stage where they might be implemented. This process is perhaps even more challenging than working out which interventions to put forward in the first place, since a number of interests are arrayed against the adoption of effective addiction interventions, not least the industries that produce potential objects of addiction. Thus, this final chapter will focus on the nature of the challenges presented by industry opposition to bold and effective addiction policies.

Previous chapters have shown that the addictiogenic environment promotes, encourages and facilitates the development of addictions. The use of legal interventions in order to control the factors of Europe's currently strong addictiogenic environment is normatively justified, and the contribution of the EU to such legal intervention is both desirable and legally possible. Such a contribution would support the Member States in developing their own national strategies on addiction and address transnational factors of the addictiogenic environment that cannot be addressed by the Member States alone.

However, despite the fact that many aspects of effective addiction policy design can be identified in the current approaches of Member States, Member States have struggled to make best use of the available evidence on the operation of the addictiogenic environment. One reason for this may be that the EU has not been delivering upon its responsibilities for contributing to addiction policy at the supranational level, failures which may not only be responsible for the lack of best practice sharing amongst the Member States, but may also be actively preventing the Member States from discharging their own addiction policy responsibilities. In order to rectify this situation, a renewed and more intense strategic approach to controlling the factors of Europe's addictiogenic environment is needed, based on the principles of holisticism, horizontality and multilevel responsibility. The design of this renewed approach to addiction policy should be guided by clearly articulated goals and policy paradigms that prompt evidence-based interventions that are well matched to those goals.

A renewed and more intense approach to addiction policy will of course attract opposition, especially from the industries that produce objects of addiction, in particular the tobacco, alcohol, gambling and unhealthy food industries, all of which are dominated by powerful and resourceful multinational corporations as highlighted earlier in the thesis. The opposition of these industry actors presents important practical challenges that must be addressed if EU policymakers are to steer policies such as the examples discussed above through the policymaking process, in pursuit of their responsibilities to contribute to renewed strategic governance of addiction in Europe. Addiction industries are single minded in their determination to protect their economic positions from any policy development that is likely to be effective in reducing consumption of their products.

This chapter will examine two particular challenges for the implementation of new addiction interventions at EU level that are connected to the industries that produce objects of addiction. The

first half of the chapter will discuss the obstacles to getting new addiction interventions onto the policymaking agenda that are presented by the policy power that the industries have amassed, while the second half of the chapter will discuss the fundamental rights-based legal challenges that the industries are likely to mount against any policies that are enacted.

II. The industry's power in the policymaking process

The most theoretically well-designed policy is all but useless if it is impossible in practice to adopt. The policymaking process can be disaggregated into a number of different stages,[876] all of which can present difficulties for the adoption of policies that are controversial or sensitive in subject matter. These stages are usually recognised in the policymaking literature as the problem definition and agenda setting stage, the policy formulation and adoption stage, the implementation stage and the evaluation stage.[877] From the point of view of policymakers seeking to steer addiction interventions, such as the ones discussed above, through the policymaking process, arguably the trickiest stage to get past is the first one – getting addiction interventions onto the policymaking agenda.

In this section I will argue that a major practical obstacle to getting new EU addiction interventions onto the policy agenda of the EU institutions is the power of addiction industries to block such interventions from gaining sufficient momentum to ascend from general political debate onto the focused policy agenda. The section will argue that industries exert the power they have amassed to draw focus away from the most influential factors of the addictiogenic environment, and to redirect attention attention instead to 'problems' that are not really problems at all. This argument will be developed by first discussing why the issue of power is essential to agenda setting, then analysing how addiction industries have acquired power, how the industry have used this power, and how the power balance might be changed so as to remove obstacles that prevent effective addiction interventions from moving through the policymaking process.

A. Why is actor power important to problem definition and agenda setting in addiction policy?

Addiction is a highly charged and complex area of public policy. The complexity of regulating substances and behaviour whose consumption can simultaneously bring pleasure and pain is summed up by Leitzel – 'many people consider themselves to be better off by drinking alcohol, or by

[876] E Versluis et al, *Analyzing the European Union Policy Process* (Palgrave MacMillan: Basingstoke 2011) 18.
[877] C Knill and J Tosun, *Public Policy: A New Introduction* (Palgrave MacMillan: Basingstoke 2012) 9.

smoking marijuana',[878] yet, 'public debate regarding vice policy is typically conducted as if vices were some sort of mysterious activities that involve only costs'.[879]

As a consequence, opinions and values have an important role to play[880] in shaping how the problems that supposedly cause addictions are defined, and in shaping how policymakers approach this problem definition process.[881]

If opinion and values are important to problem definition in the process of adopting addiction policy, it follows that the ability of political actors to manipulate opinions and values to suit their own interests can determine whether problems actually make it onto the policymaking agenda at all. As Stone notes, policy problems 'are not given out there in the world waiting for smart analysts to come along and define them correctly' – 'they are created in the minds of citizens by other citizens, leaders, organizations, and government agencies, as an essential part of political maneuvering'.[882]

Addiction industries have managed to amass sufficient power and influence so as to be able to manipulate the opinions and values of the public and policy makers alike extremely effectively, when the question of addiction appears on the policymaking horizon. The result is that most political and policymaking debates on addiction have identified weak or incorrect factors of the addictiogenic environment to tackle, and this is reflected in the public health policy agenda at EU level.

In order to reverse the influence that addiction industries are currently exerting on the policymaking process, it is necessary to examine how they have managed to acquire this power and influence. It is to this question that the next subsection turns.

B. How have addiction industries acquired policy power?

Policymaking power is the 'ability of a political actor to influence the behaviour of others in such a way as to gain a preferred outcome.'[883] As such, it must be earned, and this is usually achieved by

[878] Leitzel, n 55 above, 8.
[879] J Leitzel, n 55 above, 8.
[880] N Giesbrecht and T Greenfield, 'Public opinions on alcohol policy issues: A comparison of American and Canadian surveys' (1999) 94(4) Addiction 521.
[881] D Kahan, 'Gentle nudges vs hard shoves: Solving the sticky norms problem' (2000) 67(3) The University of Chicago Law Review 607.
[882] D Stone, *Policy Paradox and Political Reason* (Glenview, IL: Scott, Foresman and Company, 1988), 122.
[883] R Hays, *The Federal Government and Urban Housing: Ideology and Change in Public Policy* (Albany: State University of New York Press 1995), 1.

industries through processes of building social legitimacy.[884] Innate authority and the strength to act upon it – such as that conferred upon governments through democratic elections – does not generate true power. Instead, it is the perception of strength being used in a way that is socially legitimate, as well as in accordance with proper authority, that makes an actor powerful.[885] As Barnett and Finnemore note, a government becomes powerful not because it is in government, but due to 'the values it claims to embody and the people it claims to serve.'[886] Industries that produce potential objects of addiction do not benefit from the legitimising process that comes with election to public office, so have have used the following three mechanisms to build social legitimacy, and therefore power.

The first is to promote the image of being champions of prevailing popular opinion relating to addiction, particularly if this popular opinion rails against regulation. This is mostly achieved through 'media capture'.[887] The use of 'media ownership, advertising, public relationship and spin, attacking critics and … ideology'[888] in order to ensure that the media promotes an industry position that is in line with prevailing public sentiments. This gives industry operators the 'opportunity to connect with popular opinion',[889] giving the impression that industry operators are on the side of the public. The capture of media outlets also provides industry with the opposite opportunity of 'mediating popular concerns'[890] where public sentiment conversely favours regulation. The tactic of piggybacking prevailing views of addiction and addictive objects, in order to boost the public acceptability of their own views, is an effective legitimacy-building strategy for industry operators, since pushing a particular policy agenda will be successful 'to the extent [it] can be grafted on to previously accepted norms'.[891]

The second is by portraying themselves as accepted and normal parts of society. Industries market themselves and their products relentlessly in an effort to 'mask [the] uncomfortable truths [about themselves and their products] by disguising inanimate corporate monoliths as benign friends under

[884] K Buse and A Harmer, 'Power to the Partners?: The politics of public-private health partnerships', (2004) 47(2) *Development* 49, 53.
[885] ibid, 53.
[886] M Barnet and M Finnemore, *Rules for the world: International organisations in global politics* (Cornell University Press 2004), 21.
[887] D Miller and C Harkings, 'Corporate strategy, corporate capture: Food and alcohol industry lobbying and public health' (2010) 30 Critical Social Policy 564, 574.
[888] ibid, 574.
[889] ibid, 574.
[890] ibid, 574.
[891] R Price, 'Transnational civil society and advocacy in world politics' (2003) 55(4) World Politics 579, 584.

the guise of branding.'[892] In order to do this, companies invest huge sums of money in advertising, sponsorship and other promotional tools in order to broadcast a message about the company as much as the product being marketed.[893] This is done on the basis that the more the company's desired message saturates daily life, the more the company will be seen as a normal part of daily life. Sponsorship of important global events is an excellent way of achieving this – which perhaps might explain why both Coca Cola and MacDonalds have worked to secure positions as Worldwide Olympic Partners.[894] Being dubbed an official partner of a beloved global phenomenon such as the Olympic Games is something of a coup for industries wishing to portray themselves as part of the social fabric, and an effective one.[895] Such activities contribute enormously to the social legitimacy of addiction industries.

The third is by portraying themselves as part of the solution rather than as part of the problem. Industries have worked hard to turn attention away from their own activities and towards those of the individual. This is achieved through consistent and intense promotion of personal responsibility rhetoric, which attempts to push the view that individuals should be primarily responsible for their own health.[896] This then gives addiction industries the opportunity to conduct corporate social responsibility exercises, the purpose of which is supposedly to help individuals develop personal responsibility, but in reality is to show policymakers that industry operators can be helpful partners.[897] An excellent example is the creation of the Drinkaware foundation, a charity that conducts highly visible campaigns on alcohol awareness in the UK, yet was set up and continues to be run by the alcohol industry.[898] All corporate responsibility exercises are ultimately aimed at convincing policymakers that industry operators are 'part of the solution rather than the problem',[899] in order to build an aura of social legitimacy.

By building an aura of social legitimacy – primarily through manipulating public and political perceptions of their activities – addiction industries have incredibly been able to persuade governments and international organisations to formally transfer policymaking authority upon them.

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[892] Hastings, n 116 above.
[893] See for example: S Cunningham et al, 'Expressing identity and shaping image: the relationship between corporate mission and corporate sponsorship' (2009) 23 Journal of Sport Management 65.
[894] See https://www.olympic.org/sponsors (last accessed 24 September 2016).
[895] Garde and Rigby, n 236 above.
[896] D Thomson, 'Big Food and the Body Politics of Personal Responsibility', (2009) 74(1) *Southern Communication Journal* 2.
[897] S Yoon and T Lam, 'The illusion of righteousness: corporate social responsibility practices of the alcohol industry', (2013) 13 *BMC Public Health* 630.
[898] See the discussion in: J McCambridge et al, 'Be aware of Drinkaware' (2013) 109 Addiction 519.
[899] Hastings, n 116 above.

This has been seen for instance in the UK's Responsibility Deal, in which the food and alcohol industries have been invited to partner with government and where there is a 'clear presumption in favour of partnerships and voluntary regulation'.[900] Industry operators were also handed policy authority at European level in the EU Platform on Diet, Physical Activity and Health, and the EU Alcohol and Health Forum – the primary drivers of the EU's strategies in the field of alcohol and diet.[901] Furthermore, the EU Alcohol Strategy actively encouraged the involvement of the alcohol industry in policy making by making it a priority of EU level action on commercial communication to 'reach an agreement with representatives from a range of sectors (hospitality, retail, producers, media/advertising) on a code of commercial communication implemented at national and EU level'.[902]

Once addiction industry have built social legitimacy and been handed authority within the policymaking process, they are able exert real power and influence upon the policymaking process. This influence is used to keep effective addiction interventions off the policymaking agenda.

C. How have the addiction industries exerted their power in problem definition and agenda setting?

Problems must be defined in a certain way in order to make it onto the policymaking agenda[903] - the connection that is established between the proffered definition of the problem and the preferred policy outcome is essential in whether or not the problem as defined is brought onto the agenda.

The use of particular policy ideas allow problems such as addiction to be defined in ways that can be easily linked to a practical solution.[904] The 'key role of language and narrative stories in the negotiation of such definitions',[905] means that if ideas, problems and solutions are knitted together into a compelling enough narrative, a course of action that is not actually helpful in tackling addiction can make it onto the policy agenda. To recall the arguments made in the previous chapter on paradigms, paradigms are essential for linking policy goals to the interventions that are most likely to achieve them. This is because a paradigm is a 'framework of ideas and standards that

[900] Gilmore et al, n 294 above.
[901] O Bartlett and A Garde, 'The EU Platform and EU Forum: new modes of governance or a smokescreen for the promotion of conflicts of interest?' in A Alemanno and A Garde, *Regulating Lifestyle Risks: The EU, Alcohol, Tobacco and Unhealthy Diets* (Cambridge University Press, 2015) 283.
[902] Commission Communication on an EU Alcohol Strategy, n 654 above, 17.
[903] Knill and Tosun, n 877 above 106.
[904] J Campbell, 'Institutional analysis and the role of ideas in political economy', (1998) 27 *Theory and Society* 377.
[905] F Fisher, *Reframing Public Policy* (Oxford University Press 2003), 161.

specifies not only the goals of policy and the kind of instruments that can be used to attain them, *but also the very nature of the problems they are meant to be addressing*'.[906] Paradigms assume a particular problem, and guide policymakers towards appropriate solutions. This is why the selection of the right paradigm will ensure that the assumed problem is matched to the policy goals, and thus the intervention made is effective in pursuing those goals. However, if a paradigm is inappropriately chosen, the problem assumed by the intervention is not the same as the problem described by the goals, and thus the interventions taken will not be effective. Adherence to a particular policy paradigm can be deliberately engineered in order to frustrate the achievement of certain goals, or to raise the salience of new problems and new goals entirely. If this happens, then a paradigm's function of 'constrain[ing] the cognitive range of useful solutions available to policy makers',[907] will guide policymaking towards solutions that are unlikely to do anything to solve the real problems of the addictiogenic environment. If the right policy window opens up when adherence to the paradigm is particularly strong,[908] then policymakers will end up placing a 'problem' related to addiction on the agenda that in no way relates to the operation of the addictiogenic environment.

The addiction industries purposefully promote certain paradigmatic policy thinking in order to manipulate the definition of problems to suit their own interests. As noted above, the way in which this is done has to form a compelling enough narrative – as Dery explains, 'problems do not exist "out there", are not objectives entities in their own right, but are analytic constructs'.[909] To ensure that politicians and policymakers buy into the way in which their preferred paradigms construct the problems of addiction, industry operators have leant on the fact that politicians as well as consumers use certain behavioural shortcuts in their decision making. Policymakers are decision makers, just like consumers, and 'decision-makers – like all other people – have a natural limited mental capacity and are therefore only able to cope within these limits and with a limited volume of information.'[910] Furthermore, policymakers 'do not have perfect information about resulting consequences upon which to determine the best alternative [and] [a]s a consequence, there will always be uncertainty and risk about the eventual impacts of decisions taken, which means that a fully rational decision may eventually lead to an undesired effect.'[911] The framing of problems, real

[906] Hall, 'n 803 above, 279 (emphasis added).
[907] J Campbell, 'Institutional analysis and the role of ideas in political economy' (1998) 27 Theory and Society 377, 385.
[908] R Brownson et al, 'Understanding evidence-based public health policy' (2009) 99(9) American Journal of Public Health 1576, 1580.
[909] D Derry, 'Agenda setting and problem definition' (2000) 21(1) Policy Studies 37, 40.
[910] Kørnøv and Thissen, 'Rationality in decision- and policy-making: implications for strategic environmental assessment' (2000) 18(3) Impact Assessment and Project Appraisal 191, 193.
[911] ibid, 193.

or fabricated, through the promotion of particular paradigmatic policy thinking, is therefore absolutely crucial in whether or not they are adopted onto the policymaking agenda. It was shown above how adherence to the paternalist paradigm would guide policymakers towards interventions that would effectively control the addictiogenic environment. The analysis below will explore the paradigms that the addiction industries have promoted in order to guide policymakers away from effective control of the addictiogenic environment.

The addiction industries have firstly tried to promote the information paradigm, which is based around the idea that information provision is an efficient and effective way of protecting individuals. Industry promotes the idea that 'information [provision] seems to offer a win-win solution. Consumers are given the means to protect themselves and drive up standards, whilst business is allowed flexibility to provide the goods and services the market demands.'[912] This plays on the fact that the policymaking process is often 'perceived in terms of winners and losers.'[913] Ideas for policy action that appear to lead to only winners will be seen as superior by policy makers who 'deny that there are trade-offs and that there are some values which many not be served by their favoured alternative'[914] – in other words, information play upon the natural desire of policymakers to find a solution that pleases everyone. To exploit this, the addiction industries have focused on highlighting neo-classical economic views of information provision that suggest that that mere provision of information allows consumers to protect themselves and preserve their preferences, while allowing traders to innovate and drive economic growth.[915] This cements the link between information provision as a guiding idea and information provision as a serious strategy, and overpowers the conclusions of more modern studies which demonstrate the ineffectiveness of information provision in NCD prevention.[916]

The addiction industries secondly promote ideas of individual autonomy, in order to frame discussions in terms of whether interventions promote or detract from autonomy. Voters are fickle, and are 'swayed by rhetoric, framing, and advertising, and hold incumbents accountable for events

[912] G Howells, 'The potential and limits of consumer empowerment by information' (2005) 32(3) Journal of Law and Society 349, 350.
[913] Kørnøv and Thissen, n 910 above, 196.
[914] C Schwenk, 'Cognitive Simplification Processes in Strategic Decision-making', (1984) 5 *Strategic Management Journal* 111, 119.
[915] Howells, n 912 above, 355.
[916] See Anderson et al, 'Effectiveness and cost-effectiveness of policies and programmers to reduce the harm caused by alcohol' (2009) 373(9682) Lancet 2234.

that are clearly beyond the incumbent's control,'[917] and the industry play on the fact that much of the time 'politicians are motivated by their concern for re-election, office and power'[918] and therefore 'politicians who face frequent re-election often pursue short term outcomes'.[919] Promoting ideas that protecting individual autonomy in the short term will be favourable with voters, compared to the protection of longer term health concerns, therefore appeals to the short term thinking of most politicians. In aid of this, industry might highlight statistics that reinforce public approval of autonomy-preserving interventions and focus attention on philosophical discourses of autonomy.[920] Policy makers will accept this evidence far more easily than statistics that show support for potentially unpopular interventions such as restrictive marketing regulations, even if such evidence is genuine.[921]

The addiction industries thirdly promote personal responsibility paradigms, which revolve around the idea that individual behaviour is the primary factor in determining individual health. Policymakers 'often do not really know what the problem is, what to aim for, [or] how to achieve it, even less what the best way is to achieve it',[922] and therefore their 'judgement of a situation is affected by the way it is framed.'[923] When it comes to topic such as addiction with so many different factors that contribute to the problem, it is relatively simple to highlight factors that are easy to understand, and make intuitive sense, such as the idea that if individuals behaved responsibly, then they would not engage in heavy consumption of potential objects of addiction, and would not develop addictions. Despite the fact that personal responsibility, while important, is far from the decisive factor that contributes to the development of addictions, addiction industries consistently frame debates on the use of their products in these personal responsibility terms, making sure that 'those afflicted by chronic disease are generally represented as the agents of their own misfortune, typically because they have freely chosen particular health-damaging behaviours.'[924] This representation of the 'problem' is much easier for policymakers to understand and focus their attention on than evidence which suggests that the real problem is constituted by a complex web of

[917] D Diermeier, 'Institutionalism and the Normative Study of Politics: From Rational Choice to Behavioralism', (2015) 24(1) *The Good Society* 15, 21.
[918] J Christensen and V Nielsen, 'Administrative capacity, structural choice and the creation of EU agencies', (2010) 17(2) *Journal of European Public Policy* 176, 184.
[919] R Geneau et al, 'Raising the priority of preventing chronic diseases: a political process', (2010) 376 *Lancet* 1689, 1691.
[920] On the use of ideological discourses by the tobacco industry, see: J Cohen et al, 'Political ideology and tobacco control', (2000) 9 *Tobacco Control* 263.
[921] Special Eurobarometer 331, *EU citizens' attitudes towards alcohol*, available online at http://ec.europa.eu/public_opinion/archives/ebs/ebs_331_en.pdf (accessed 1 October 2015).
[922] Kørnøv and Thissen, n 910 above, 194.
[923] ibid, 193.
[924] Geneau et al, n 919 above, 1692.

factors, the sum of which is an environment that goes to the heart of policymaking processes themselves.

The addiction industries have been successful in promoting adherence to these policy paradigms. For example, the UK Alcohol Strategy adopted in 2012 states plainly that 'a combination of irresponsibility, ignorance and poor habits – whether by individuals, parents or business'[925] was responsible for alcohol related harm, that the strategy 'seeks to turn the tide against irresponsible drinking',[926] and that in pursuit of this goal the strategy will 'secure industry's support in changing individual drinking behaviour'[927] and 'support individuals to make informed choice about healthier and responsible drinking, so it is no longer considered acceptable to drink excessively'.[928] Although encouraging responsibility when engaging with alcohol is a valuable goal of any strategy that seeks to weaken part of the addictiogenic environment, the level of focus on irresponsibility and the individual in the UK Alcohol Strategy is misguided, and plays perfectly into the hands of the industry.

Alcohol policy at EU level similarly displays evidence of the information provision and personal responsibility paradigms promoted by the industry. Of the commitments adopted by EU level stakeholders in the EU Alcohol Forum, 70 per cent focus on organising campaigns to raise awareness of the harmful effects of alcohol, or on responsible drinking.[929] Furthermore, information provision is a major component of the Commission's Recommendation on Online Gambling – in the Preamble to the Recommendation, the information provision is suggested to be a suitable way of protecting consumers on eight occasions,[930] yet interventions on commercial communications are raised on only five.[931] This is perhaps indicative of where the focus on the Commission's Recommendation truly lies.

In summary, the addiction industries have managed to built social legitimacy and acquire policymaking power, particularly at EU level. They have then exerted this power in order to promote promote paradigmatic ideas of information provision and personal responsibility in the policymaking

[925] *The Government's Alcohol Strategy* (London: Home Office, 2012) available online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf (last accessed 15 February 2016), 3.
[926] ibid, 4.
[927] ibid, 4.
[928] ibid, 4.
[929] Bartlett and Garde, n 674, 289.
[930] Commission Recommendation 2014/478/EU on principles for the protection of consumers and players of online gambling services and for the prevention of minors from gambling online, OJ L 214/38, 19.7.2014, paras 3, 10, 11, 15, 17, 22, 26, 27.
[931] ibid, paras 3, 6, 11, 13, 17.

process, which has resulted in national and EU level policy agendas filling up with the pursuit of interventions that seek to rectify irresponsibility and individual failure, while promoting partnerships with industry operators, at the expense of interventions that would seek to control the truly problematic factors of the addictiogenic environment, of which the addiction industries themselves are a major part.

Power in the initial stages of the policymaking process is therefore crucial in shaping the eventual success of interventions that are ostensibly aimed at reducing the prevalence of addictions. The next section will discuss strategies for how the public health community can try to weaken the social legitimacy, and therefore the policy power, of the addiction industries.

D. How can the power balance be moved away from commercial interests?

As can be seen from the section above, the ability of the addiction industry to promote their preferred interpretation of the addiction problem to the policy agenda has resulted in much ineffective interventions being pursued. In order to refocus the agenda onto effective legal interventions, as part of a renewed strategic approach to addiction policy, it is imperative that the public health community weaken the ability of the industry to influence problem definition in addiction policy. This can be achieved through the following strategies, if the public health community are able to commit whole-heartedly to them.

First, the public health community must organise far more effectively in order to present a united front that, put simply, is able to shout louder than the industry in political debate. At the moment, the public health community 'suffers from poor articulation, image, and understanding',[932] and in order to become a stronger voice in the political debate, public health advocates must create stronger, more visible and easier to understand image, which can be presented to the public. Addiction industries present an image to the public that is clear and obvious in its message. The public health community must do the same. Public heath work has also 'become increasingly fragmented into disciplinary silos,'[933] with experts approaching the same problem independently of each other. This must change – public health advocates and experts must *all* work together, pooling their knowledge to contribute a single argument to political debate, rather than many, potentially conflicting arguments. As Lang and Rayner note, 'specialists need to be noisy and to build

[932] T Lang and G Rayner, 'Ecological public health: the 21 century's big idea? An essay by Tim Lang and Geof Rayner', (2012) 345 *British Medical Journal* e5466.
[933] Hastings, n 116 above.

alliances.'[934] The end goal of this collaborative effort is to establish the same 'boldness of purpose'[935] that drives the industry. It is only by shouting as loudly and as clearly as industry operators that the policymaking paradigms that would lead to effective action on the factors of the addictiogenic environment can be promoted.

Second, the public health community must take action to publicise the addiction industries' tactics and practices, in an effort to break down the façade of social legitimacy that they have created. Analysis of internal industry documentation has already taken place in academic forums, showing the industry's intent to recruit consumers early, exploit them, and keeping them consuming.[936] This must be replicated in more popular forums than academia, in order to more widely communicate the message that industry operators intentionally disguise the true motives that lie behind their activities. As Oliver remarks, efforts to change the image portrayed by industry 'are most potent in triggering policy initiatives when harmful consequences are viewed as intentional rather than accidental.'[937] Success in tobacco control can be attributed in no small part to 'perceptions of a demon industry'[938] that purposefully manipulated youngsters and concealed evidence on tobacco harm from the public. Although this imagery is perhaps too strong for less homogenous industries such as alcohol and food, within which there are smaller entities with less irresponsible motives, a more widespread perception of the most powerful multinational alcohol and food corporations as unfriendly to population health interests could be pursued. This will begin to undermine the perception of such corporations as benign entities that simply provide products that are a desirable and normal part of modern life.

In sum, those with the knowledge of how industries build social legitimacy and manipulate the policymaking process in their favour must be noisier in bringing this to the attention of the public. The ability of the addiction industries to distract policymakers from the really important tasks in addiction prevention is a major potential obstacle to a renewed effort to address the addictiogenic environment in a stronger and more strategic fashion, yet this ability rests on the perception of the industries as socially legitimate. Removing this legitimacy would go a long way towards removing this particular obstacle. The addiction industries do not just present obstacles at the start of the

[934] Lang and Rayner, n 392 above.
[935] Hastings, n 116 above.
[936] See for example: Hastings, n 119 above; L Bero, 'Implications of the Tobacco Industry Documents for Public Health and Policy', (2003) 24 *Annual Review of Public Health* 267; P Ling and S Glantz, 'Why and How the Tobacco Industry Sells Cigarettes to Young Adults: Evidence From Industry Documents', (2002) 92(6) *American Journal of Public Health* 908.
[937] Oliver, n 651 above, 199.
[938] ibid, 200.

policymaking process however, but also at the end. Even if the industries are unsuccessful in preventing effective addiction interventions from making it onto the agenda and all the way through to implementation, they still wield another powerful weapon that could prevent effective addiction policies from sticking. This weapon is the challenge to the legality of interventions on the grounds that they contravene the fundamental rights of businesses. It is to how this obstacle might be overcome that the second half of this chapter turns.

III. The fundamental rights objections that industry could raise

A more intense approach to controlling the factors of the addictiogenic environment, several of which are concerned with the actions of corporations that produce objects of addiction, will necessarily involve restricting the actions of these corporations or mandating that they take certain actions. This means that many of the interventions that are discussed in this thesis potentially infringe the fundamental rights of corporations. In order to ensure that effective addiction interventions that do make it onto the policymaking agenda are actually implemented, they must be defended from the legal challenges advanced by the addiction industries must be devised.

This section will argue that the two most important potential conflicts will be with the freedom of commercial speech and the freedom to carry out a business, both of which are enshrined in the EU Charter of Fundamental Rights. It will further argue that it is possible to justify restrictions of the rights of corporations as proportionate to the pursuit of public health objectives.

A. How can intervention be balanced with commercial speech rights?

Many interventions adopted to weaken the addictiogenic environment will be directed specifically at restricting the ability of industry operators to manipulate the information environment surrounding potential objects of addiction. These will take the form of advertising restrictions, disclosure requirements, restrictions on sponsorship and product placement, restrictions on the release of Internet content, and other related interventions. These interventions all come into conflict with the established rights of commercial operators to freedom of speech, and as such are likely to attract legal challenge.

Under the EU Charter of Fundamental Rights (CFREU)[939] – legally binding as of 2009 – the right to freedom of expression is protected by Article 11, which states that ‘everyone has the right to

[939] Charter of Fundamental Rights of the European Union [2000] OJ C 364/1, 18.12.2000.

freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers'.[940] According to Article 52(3) of the Charter, if Charter rights 'correspond to rights guaranteed by the Convention for the Protection of Human Rights and Fundamental Freedoms' – the European Convention on Human Rights (ECHR) – then 'the meaning and scope' of the Charter rights 'shall be the same as those laid down by the said Convention'.

Article 10 ECHR corresponds to Article 11 CFREU. The European Court of Human Rights (ECtHR) has interpreted Article 10 ECHR to include the right of commercial free speech. For example, in *Markt Intern* the ECtHR held that commercial expression 'cannot be excluded from the scope of Article 10 … which does not apply solely to certain types of information or ideas or forms of expression'.[941] More specifically in *Casado Coca*, the ECtHR stated that 'Article 10 guarantees freedom of expression to "everyone". No distinction is made in it according to whether the type of aim pursued is profit-making or not'.[942] They went on to state that Article 10 'included the freedom to impart information and its corollary, the right to receive it',[943] and that 'for the citizen, advertising is a means of discovering the characteristics of services and goods offered to him'.[944] Commercial advertising therefore clearly falls within the scope of Article 10 ECHR as the 'paradigmatic case of commercial expression'.[945]

As a result of this body of case law, EU law – and specifically Article 11 of the Charter - must be understood to protect the freedom of commercial operators to advertise or otherwise market their products. As such, numerous objections have been made against EU laws that seek to restrict the marketing activities of commercial operators in pursuit of the objective of public health protection. For example, in *Imperial Tobacco*, tobacco producers applied for judicial review of the UK's intention to give effect to the provisions of the Tobacco Advertising Directive, and argued that commercial speech is protected by EU, and improvement of the internal market is not a permissible ground upon which to restrict speech relating to lawfully marketable products.[946] In *Neptune Distribution*, the manufacturers of sparkling water argued that obliging them to remove packaging claims relating to

[940] Article 11(1).
[941] *Markt Intern v Germany* App no 10572/83 (ECHR, 20 November 1989), para 26.
[942] *Casado Coca v Spain* App no 15450/89 (ECHR, 24 February 1994), para 35.
[943] ibid, para 49.
[944] ibid, para 51.
[945] M Randall, 'Commercial speech under the European Convention on Human Rights: Subordinate or Equal?' (2006) (6)1) Human Rights Law Review 53, 60.
[946] See the Opinion of Advocate General Fennelly, delivered on 15 June 2000 in Case C-74/99 *The Queen v Secretary of State for Health and Others, ex party Imperial Tobacco Ltd and Others* [2000] ECLI:EU:C:2000:547.

salt content interfered with their freedom of expression.[947] Finally, in *Tobacco Advertising 2*, it was argued that bans on cross-border tobacco advertising would be likely to hamper the activities of the press, and thus prejudice the enjoyment of freedom of expression.[948]

Despite these objections, ECHR and EU jurisprudence plainly recognise that the freedom of expression is not absolute. Article 10(2) ECHR states that freedom of expression 'may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society … for the protection for health or morals'. The case law of the ECtHR confirms that restrictions may therefore be placed on commercial speech. In *Casado Coca*, it was stated that advertising:

> 'may sometimes be restricted, especially to prevent unfair competition and untruthful or misleading advertising. In some contexts, the public action of even objective, truthful advertisement might be restricted in order to ensure respect for the rights of others or owing to the special circumstances of particular business activities and professions'.[949]

The margin of the discretion that the ECtHR affords to have further confirmed that a margin of discretion must be given to public authorities when they decide that a restriction of freedom expression for the above purposes is necessary, and that this margin may be broader where some types of expression are concerned. In the case of *Mouvement Raëlien Suisse,* the ECtHR confirmed that 'the breadth of such a margin of appreciation varies depending on a number of factors, among which the type of speech at issue is of particular importance … States have a broad margin of appreciation in the regulation of speech in commercial matters or advertising'.[950] Thus, it 'would seem that restriction on commercial speech may be compatible with the Convention so long as a state reasonably views them as necessary … for example, a state's restrictions on tobacco advertising, with the aim of the protection of health, are likely to be compatible with Article 10 provided they are not disproportionate'.[951]

This case law has been reflected in the CFREU, and in accordance with Article 52(3) CFREU has been followed by the CJEU in their interpretation of Article 11 CFREU. The CFREU acknowledges that limitations might be made on the freedoms it guarantees, but that these 'must be provided for by

[947] Case C-157/14 *Neptune Distribution* [2015] ECLI:EU:C:2015:823.
[948] *Germany v Parliament and Council*, n 626 above.
[949] *Casado Coca v Spain,* n 942 above, para 51.
[950] *Mouvement Raëlien Suisse v Switzerland* App no 16354/06 (ECHR, 13 July 2012), para 61.
[951] C Munro, 'The value of commercial speech' (2003) 62 The Cambridge Law Journal 134, 141.

law and respect the essence of those rights and freedoms',[952] and furthermore that '[s]ubject to the principle of proportionality, limitations may be made only if they are necessary and genuinely meet objectives of general interest recognised by the Union or the need to protect the rights and freedoms of others'.[953]

EU case law confirms that Article 11 CFREU may be restricted in a proportionate manner so that certain overriding imperatives may be realised, and that a margin of discretion is afforded to Member States in this process. The CJEU set out in *Karner* that:

> 'whilst the principle of freedom of expression is expressly recognised by Article 10 ECHR … freedom of expression is also subject to certain limitations justified by objectives in the public interests … that is to say justified by a pressing social need and, in particular, proportionate to the legitimate aim pursued'.[954]

The Court continued to state that:

> 'the discretion enjoyed by the national authorities in determining the balance to be struck between freedom of expression and the above mentioned objectives varies for each of the goals justifying restrictions on that freedom and depends on the nature of the activities in question. When the exercise of the freedom does not contribute to a discussion of public interest and, in addition, arises in a context in which the member States have a certain amount of discretion, review is limited to an examination of the reasonableness and proportionality of the interference'.[955]

These principles have been applied by the CJEU to instances of commercial expression, establishing that the right of commercial operators to market their products may – especially in view of the nature of commercial speech – be restricted in a proportionate manner when there is a pressing social need, such as protecting public health or upholding the right to health. In the case of *Neptune Distribution* the CJEU held that 'the need to ensure that the consumer has the most accurate and transparent information possible concerning the characteristics of goods is closely related to the protection of human health and is a question of general interest … which may justify limitations on

[952] Article 52(1) of the Charter.
[953] Article 52(1) of the Charter.
[954] Case C-71/02 *Karner* [2004] ECLI:EU:C:2004:181, para 50.
[955] ibid, para 51.

the freedom of expression'.[956] The CJEU furthermore held that if public health measures conflict with the freedom of expression, 'the determination of the validity of the contested provisions must be carried out in accordance with the need to reconcile the requirements of the protection of those various fundamental rights protected by the EU legal order, and striking a fair balance between them'.[957]

Under the CJEU's jurisprudence therefore, 'the extent to which public authorities may restrict the marketing of harmful goods and services with a view to protecting public health very much rests on determining how competing interests should be balanced against each other'.[958] However, it is also clear that 'the Court has tended to grant an extremely broad margin of discretion to the EU legislature in determining how far it would restrict fundamental rights to ensure a high level of public health protection'.[959] This has argue been due, as Alemanno and Garde point out, to the fact that 'the Court has not substituted its assessment to that of the legislature'[960] – they make the point that despite the consequence of this deference being the 'failure to engage effectively with existing evidence demonstrating the proportionality'[961] of lifestyle regulation measures, notably in *Tobacco Advertising 2*, from the perspective of balancing the fundamental rights of industry with the protection of public health, 'the outcome … is nonetheless compelling'.[962]

Thus, as with the question of balancing public health protection with internal market obligations, the question of the proportionality of measures is the fulcrum upon which the balancing of addiction interventions with commercial speech turns. The principle of proportionality 'requires the means employed by a Community provision to be appropriate for attaining the objective pursued and not to go beyond what is necessary to achieve it'.[963] The CJEU was called to rule directly on the proportionality of a lifestyle regulation that allegedly abridged commercial expression for the first time in Tobacco Advertising 2. As noted above, the response from the Court was disappointing. After reviewing the arguments, the Court simply notes that the Community legislature enjoys a wide discretion in this area, and that the legality of a ban on tobacco advertising 'can be affected only if the measure is manifestly inappropriate having regard to the objective which the competent

[956] *Neptune Distribution* n 947 above, para 74.
[957] ibid, para 75.
[958] A Garde, 'The freedom of commercial expression and public health protection in Europe' 12 Cambridge Yearbook of European Legal Studies 225, 245.
[959] Alemanno and Garde, n 142 above, 1782.
[960] ibid.
[961] ibid.
[962] ibid.
[963] *Germany v Parliament and Council*, n 626 above, para 144.

institutions are seeking to pursue'.[964] A total of twelve paragraphs later,[965] the court had concluded, that the tobacco advertising ban was within the limits of the legislature's discretion, without having provided any substantive indication of *why* the measure was proportionate. Thus, the case left the question of the extent to which lifestyle interventions, including interventions that seek to control factors of the addictiogenic environment, rather unsatisfied.

This may, however, have been rectified recently. In the judgement in *Phillip Morris Brands,*[966] the proportionality of a particularly high profile tobacco control intervention, the revised Tobacco Products Directive adopted in 2014, was resoundingly supported by both Advocate General Kokott and the CJEU. The Opinion and Judgement gives a more satisfying account of *why* the balance between protecting public health and protecting commercial speech might be tipped in favour of protecting health.

The Comments of Advocate General Kokott are illuminating. Phillip Morris brought an action in the English High Court seeking to prevent the implementation in the UK of the revised Tobacco Products Directive.[967] In her Opinions, the Advocate General made it quite clear that 'the protection of human health has considerably greater importance in the value system under EU law than such essentially economic interests [as commercial speech] … with the result that health protection may justify even substantial negative economic consequences for certain economic operators'.[968] In light of the fact that 'the dissemination of opinions and information which – as in this case – are intended to pursue solely business interests generally warrants less protection as a fundamental right than other expressions of opinion in the economic sphere',[969] the Advocate General advised the CJEU that restriction on tobacco marketing were not disproportionate to the public health objectives pursued, and that 'the undertakings concerned must, in the interest of a high level of health protection, accept the limitation… of their opportunities to promote their products'[970] and that 'the essence of freedom of expression … is likewise not affected if commercial communications by undertakings which are intended solely to promote sales are restricted'.[971]

[964] ibid, para 145.
[965] ibid, paras 146 to 157.
[966] *Philip Morris Brands*, n 489 above.
[967] Directive 2014/40/EU [2014] OJ L 127, 29.4.2014, p 1-38.
[968] Opinion of Advocate General Kokott, delivered on 23 December 2015 in Case C-547/14 *Philip Morris Brands and Others* [2015] ECLI:EU:C:2015:853, para 179.
[969] ibid, para 233.
[970] ibid, para 235.
[971] ibid, para 236.

The CJEU responded positively to the Advocate General's Opinion, and upheld the restriction upon the freedom of expression as proportionate. In particular, the CJEU this time engaged with the public health evidence base, and noted that 'given that it is undisputed that tobacco consumption and exposure to tobacco smoke are causes of death, disease and disability' legislation banning promotional or health claims on tobacco packaging 'contributes to the achievement of [the public health] objective'.[972] The Court went further, and noted that due to the requirements of Article 168(1) TFEU and Article 35 CFREU to mainstream a high level of human health protection, there is a need 'to reconcile the requirements of the protection of those various fundamental rights'.[973] The Court, upon weighing the competing interests, concluded that 'human health protection - in an area characterised … by the addictive effects of tobacco …outweighs the interests put forward by the claimants'[974] on account of the fact that, as the Court insists plainly, 'as is apparent from … Article 35 of the Charter and Articles 9 TFEU, 114(3) TFEU and 168(1) TFEU, a high level of human health protection must be ensured in the definition and implementation of all the European Union's policies and activities'.[975] Thus, the Court suggests that public health interests, including the concern to prevent addiction, will outweigh commercial interests precisely because the EU is under a legal obligation to ensure a high level of health in its policy activities – an objective that, on the evidence, should be achieved with stringent tobacco control measures.

This level of judicial support for public health interventions that seek to control the marketing of potential objects of addiction means that it is possible to overcome objections to an EU addiction strategy that are made on the basis of conflict with freedom of expression. As long as the interference are proportionate, European case law will support the implementation of strong addiction interventions that restrict the free speech rights of corporations in order to protect the public's health. The next subsection discusses whether the same is true for interventions that restrict the right to carry out a business.

B. How can intervention be balanced with rights to carry out a business?

Any interventions within an addiction strategy that seek to reduce the ability of commercial operators to sell their products to the public, including but not restricted to marketing, may also infringe the rights of those operators to conduct a business. These interventions may take the form

[972] *Philip Morris Brands*, n 489 above, para 152.
[973] ibid, para 154.
[974] ibid, para 156.
[975] ibid, para 157.

of restrictions on the placement and character of retail outlets, age restrictions, licensing restrictions, prohibitions on promotional tactics, regulation of branding, and related measures.

Under the CFREU, the freedom to conduct a business is protected by Article 16, which states that 'the freedom to conduct a business in accordance with Community law and national laws and practices is recognised'. There is no corresponding right to conduct a business under the ECHR, so therefore the content of the right has been determined solely through EU case law, as was made clear by the CJEU in *Sokoll-Seebacher*.[976]

The freedom to conduct a business has been described as 'one of the less traditional rights contained in the Charter',[977] which 'introduces a concept crucial to modern society … about enabling individual aspirations to flourish, about encouraging entrepreneurship and innovation, and about social and economic development'.[978] The freedom to conduct a business as guaranteed by Article 16 CFREU is therefore inextricably linked to the objective of economic growth and recovery, and as such is an important freedom to protect.[979] As Groussot and colleagues explain, 'effective competition between businesses is a key principle for economic growth and stability. Therefore the freedom to operate a business or engage in enterprise without unnecessary state intervention in an almost universally acknowledged requirement'.[980]

EU case law has established that the legal content of Article 16 'covers the freedom to exercise an economic or commercial activity, the freedom of contract and free competition'.[981] Moreover, Article 16 specifically covers 'the freedom to choose with whom to do business, and the freedom to determine the price of a service'.[982] This broad scope of application means that a large number of commercial activities undertaken by corporations that produce potential objects of addiction are potentially protected by Article 16 CFREU.

However, although several types of activity might be protected, the interference with the activity made by the public health measures in question needs to be sufficiently intense in order to trigger

[976] Case C-367/12 *Sokoll-Seebacher* [2014] ECLI:EU:C:2014:68.
[977] *Freedom to conduct a business: exploring the dimensions of a fundamental right* (Vienna: European Agency for Fundamental Rights, 2015), 3.
[978] ibid, 3.
[979] ibid, 3.
[980] X Groussot et al, 'Weak right, strong court – the freedom to conduct business and the EU Charter of Fundamental Rights' (2014) Lund University Legal Research Paper Series, No 01/2014 available online at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2428181 (last accessed 26 September 2016), 1.
[981] Case C-477/14 *Pillbox 38* [2016] ECLI:EU:C:2016:324, para 155.
[982] Case C-283/11 *Sky Osterreich* [2013] ECLI:EU:C:2013:28, para 43.

Article 16 CFREU. Advocate General Kokott indicated in relation to advertising that 'it is more difficult for an operator to exercise its freedom to conduct a business if it is not permitted to advertise its products or may do so only to a limited degree'.[983] From this we might infer that any measure that makes it *more difficult* for a producer commercial operators to engage in the commercial activities outlined above would conflict with the freedom to conduct a business. This appears to be confirmed by *Neptune Distribution*, where the Court held that where a measure simply makes commercial activities 'subject to certain conditions'[984] or 'merely controls, in a very clearly defined area'[985] a particular commercial activity, the 'actual content' of the freedom to conduct a business … is not affected'.[986] Thus, for Article 16 CFREU to be triggered, the actual substance of the freedom has to be affected, in a way that makes exercise of that content more difficult.

Several objections to public health measures have been raised by commercial operators on the basis that they restrict their freedom to conduct a business. For example in *Deutchers Weintor*, alcohol producers complained that restrictions preventing them from making certain health claims about their products in promotional literature prevented the exercise of the freedom to conduct a business.[987] In *Neptune Distribution* the prohibition of health claims was also at issue, but this time the complaint of conflict with the freedom to conduct a business related to claims made on packaging. In the gambling field, gambling operators complained in *Pfleger* that making the operation of gambling machines subject to authorisation by the state was, in addition to being a restriction on the freedom to provide services under internal market law, also a violation of the freedom to conduct a business under the Charter.[988] Finally, in the case of *Sokoll-Seebacher*, a pharmacist complained that strict rules controlling where and when new pharmacies might be opened based on the determination of necessity were contrary to her freedom to conduct a business.[989]

However, in all of the above cases and many more, the CJEU has confirmed that, as with the freedom of expression, the freedom to conduct a business is not absolute. Public authorities may enact measures that restrict the freedom to conduct a business as long as these restrictions are

[983] Opinion of Advocate General Kokott, delivered on 23 December 2015, in Case C-477/14 Pillbox 38 [2015] ECLI:EU:C:2015:854, para 184.
[984] *Neptune Distribution,* n 947 above, para 70.
[985] ibid, para 71.
[986] ibid, para 70.
[987] *Deutsches Weintor*, n 629 above.
[988] Case C-390/12 *Pfleger* [2014] ECLI:EU:C:2014:281.
[989] *Sokoll-Seebacher* n 976 above.

made in pursuit of the public interest, and are proportionate. *Deutsches Weintor* may be considered the seminal case in the CJEU's approach to how the right to conduct a business might be restricted in pursuit of public health objectives. The CJEU established that the freedom to conduct a business 'is not an absolute right but must be considered in relation to its social function',[990] and furthermore that 'restrictions may be imposed on the exercise of those freedoms, provided that those restrictions in fact correspond to objectives of general interests pursued by the European Union and do not constitute, with regard to the aim pursued, a disproportionate and intolerable interference, impairing the very substance of those rights'.[991] The CJEU furthermore established that where other important Charter freedoms are at stake – in this case the protection of health under Article 35 CFREU – then the measures impugned 'must be assessed in the light not only of the freedom to choose an occupation and the freedom to conduct a business, but also of the protection of health'.[992]

The CJEU concluded that, in striking a fair balance between the protection of health and the right to conduct a business, the 'risks of addiction and abuse'[993] should make alcohol 'subject to particularly strict regulation'.[994] The Court held that 'measures restricting the advertising of alcoholic beverages in order to combat alcohol abuse reflect public health concerns and that the protection of public health constitutes … an objective of general interest justifying … a restriction of a fundamental right'. In this instance, such regulation was 'necessary to ensure compliance with the requirements that stem from Article 35 of the Charter'. [995] Thus it appears that 'the grounds that can justify a member state's limitation of the free movement of goods can also justify the EU legislator to limit human rights.[996] In view of the Charter obligation, the CJEU felt moved to declare that restrictions on business pursuits were made 'in one specific respect, compliance with those freedoms is nevertheless assured in the essential respects',[997] and that therefore the 'the prohibition at issue does not in any way affect the actual substance of the freedom to choose an occupation or of the freedom to conduct a business'.[998]

[990] *Deutsches Weintor*, n 629 above, para 54.
[991] ibid, para 54.
[992] ibid, para 46.
[993] ibid, para 48.
[994] ibid, para 48.
[995] ibid, para 53.
[996] B van der Meulen and E van der Zee, '"Through the wine gate" First steps towards human rights awareness in EU food (labelling) law' [2013] 1 European Food and Feed Law Review 41, 51.
[997] *Deutsches Weintor*, n 629 above, para 56.
[998] ibid, para 58.

While the judgement has been criticised for the weakness of its fundamental rights analysis,[999] *Deutsches Weintor* nonetheless offers promising authority that the freedom to conduct a business may be restricted, proportionately, in the legitimate pursuit of public health policy goals. This, potentially, should allow the EU legislature to 'invoke rights-based arguments'[1000] in order to control factors of the addictiogenic environment such as irresponsible marketing 'far more strictly than they have done to date'.[1001] This potential has arguably been borne out in the recent case of *Pillbox 38,*[1002] the third of three concurrent challenges in 2016 to the validity of the revised Tobacco Products Directive, and a further statement in favour of the primacy of health protection in the adoption of addiction interventions. After noting the right to conduct a business 'does not constitute an unfettered prerogative'[1003] – a slightly more confrontational wording perhaps suggesting a new hostility to industry use of fundamental rights to challenge EU legislation – the Court claimed that Article 16 CFREU 'may thus be subject to a broad range of interventions … reflected in the way in which Article 52(1) of the Charter requires the principle of proportionality to be implemented'.[1004] Without much further analysis, the Court curtly concluded that the prohibition placed on the promotion of electronic cigarettes, 'does not affect the essence of the freedom to conduct a business … neither that provision … no indeed any other… prevents economic operators from manufacturing and marketing electronic cigarettes in compliance with the conditions laid down'.[1005] While the *Pillbox 38* case may be considered a slightly unsatisfactory follow up to *Deutsches Weintor* in terms of analytical quality,[1006] it certainly shows the CJEU's wiliness to reject the fundamental rights objections of the tobacco industry to effective interventions designed to control factors of the addictiogenic environment.[1007]

[999] See for example: T Mylly, 'CJEU approves ban on health claims related to alcoholic beverages' [2013] 2 European Journal of Risk Regulation 271.
[1000] Bartlett and Garde, n 670 above, 519.
[1001] Bartlett and Garde, n 670 above, 519.
[1002] *Pillbox 38*, n 981 above.
[1003] ibid para 157.
[1004] ibid, para 158-159.
[1005] ibid, para 161.
[1006] The discussion on fundamental rights does not address the limitation of commercial expression in response to a challenge against a marketing restriction. The judgment also seems to employ a rather dismissing and circular reasoning – arguing that the directive does not prevent the manufacture or marketing of electronic cigarettes in compliance with the conditions of the directive (at para 161), is obvious, and does little to address whether it interferes with the ability of corporations to manufacture and market electronic cigarettes in any way they want.
[1007] Literature is already accumulating on the *Pillbox 38*, *Phillip Morris* and *Poland v Parliament and Council* judgements, providing initial reaction to the way the CJEU handled the fundamental rights aspects. See: P Koutrakos, 'Reviewing harmonization: the Tobacco Products Directive judgments' (2016) 41(3) European Law Review 305; R Perotti, 'New Tobacco Products Directive: the CJEU says it is compatible with EU law' (2016) Journal of Intellectual Property Law and Practice doi: 10.1093/jiplp/jpw095.

The judgements in *Deutches Weintor* and *Pillbox 38* could therefore be said to support the pursuit of addiction interventions that restrict the freedom to conduct a business. Considering the range of addiction measures that involve such a restriction– advertising restrictions, labelling restrictions, licensing rules, built environment control, and many more – this constitutes a welcome boost to the armoury of governments and public authorities for defending strong addiction interventions from the fundamental rights-based legal challenges brought by corporations.

IV. Conclusion

This chapter has sought to show that it is possible to overcome practical challenges to the adoption and implementation at EU level in particular of strong legal interventions that seek to impose renewed control over the factors of the addictiogenic environment.

The power of the addiction industries is not impossible to overcome, although it might seem that their influence upon policy represents a substantial barrier to bold action. For all the power that they hold, they lack the authority to shape the conditions in which populations will interact with their products. That authority remains with public authorities alone, and the building of a critical mass of belief in this fact will enable public authorities to take back control of the policy process that private interests are currently co-opting.[1008] While this might sound beguilingly straightforward, the building of this critical mass will be tough.[1009] Once accomplished though, it will begin an irreversible process of the de-legitimisation of addiction corporations as policy actors.[1010] We have already seen this process beginning in the tobacco field – with concerted effort, it will spread to all others.

Even with addiction industries de-legitimised as policy actors, the question of fundamental rights remains. It is not possible to de-legitimise the rights of businesses to free speech, even though we might decry what addiction corporations do with this speech. Instead, we must find legal arguments with which to rebut the arguments of the industry that free speech rights should prevail over the right of individuals to health, whenever a conflict between the two imperatives arises. This is not straightforward from a legal point of view. Through the careful interpretation of the EU Treaties, the ECHR and CFREU, and the principle of proportionality, with reference to the commitments of the EU

[1008] S Glantz and M Gonzalez, 'Effective tobacco control is key to rapid progress in reduction of non-communicable diseases' (2012)379 Lancet 1269, 1270.
[1009] For an illustration of how the process of building political support for action on public health problems such as addiction prevention can be organised, see: Geneau et al, n 919 above.
[1010] On the process of de-legitimising the tobacco industry, see: R Malone et al, 'Tobacco industry denormalisation as a tobacco control intervention: a review' (2012) 21 Tobacco Control 162.

and its Member States at the international level to implement effective standards of public health protection,[1011] it will be possible to secure the legal backing that innovative action in the addiction field will require.

This chapter represents the conclusion of the argument that has been developed throughout this thesis. The foregoing analysis has attempted to show that addiction is a serious public health and social problem, that action in order to reduce preventable addictions is normatively justified, and that the EU in particular has the mandate and the powers to contribute to solving a problem that is in part inherently transnational in nature. However, neither EU Member States nor EU institutions have found a way of effectively addressing this problem, with the EU in particular being poor in discharging its duties to support the Member States at the supranational level of addiction policymaking. A renewed, strategic approach to addiction policy is therefore needed, with more intense and effective interventions that will target the most important factors of the addictiogenic environment. Strategic action must be well designed if it is to be effective, and it was argued that any addiction strategy should be designed upon the basis of policymaking principles that reflect the evidence of how the addictiogenic environment works. Several novel interventions could be envisaged within this framework, particularly at EU level. However, as this final chapter has highlighted, if policymakers in Europe are to embrace such interventions, then certain challenges will present themselves and will need to be overcome, not least those posed by the opposition of the addiction industries. With the analysis complete, the following concluding chapter will attempt to summarise the main lessons that can be drawn, and how these lessons might be acted upon in years to come.

[1011] For an analysis of the implications of the commitments Member States have made at WHO level in the alcohol control field, see: Bartlett and Garde, n 661 above.

CHAPTER NINE – CONCLUSION

I. Initial Remarks

This thesis has attempted to show that it is possible and necessary for the EU to take a far more active role in tackling the factors of the addictiogenic environment in Europe. The existence of right to health and stewardship obligations means that ineffective control of environmental factors that promote, encourage and facilitate high levels of addiction in Europe cannot be accepted, especially given the level of evidence that now supports courses of actions that would be effective in controlling these factors. Member States employ highly diverse approaches to addiction policy that often conflict with their obligations under the EU treaties, and the EU has not been effective in

brokering supranational coordination of responses to transnational addictiogenic environment factors. A new approach level is needed – on the one hand to encourage the sharing of well-conceived addiction governance ideas between Member States, and on the other to provide a focussed framework within which the EU can concentrate on adding value to addiction policy where it should be adding value, through the exercise of its public health, social and internal market competences.

The major insights gained from the analysis conducted in this thesis on the control of the addictiogenic environment are summarised below, along with some reflections upon how this knowledge might be acted upon in future years.

II. Effective addiction policy is not extensively practiced

The first clear point that the analysis in this thesis reveals is that good addiction policy based on available evidence – that is to say, policy that embraces the principles of holisticism, horizontality *and* action on multiple levels – is not extensively practised either within Member States or at EU level. Of course, in the decades that addiction has been a policy issues for Member States, some have put in place strategic approaches to addiction policy that are evidentially and theoretically likely to produce effective results. However, as has been pointed out repeatedly in the analysis, addiction is a particularly intractable problem, and therefore an approach that is anything less than fully coherent and fully evidence based will be highly unlikely to reduce the prevalence of preventable addictions to the fullest possible extent. No Member State has yet implemented an addiction strategy that manages to reflect the three key principles of holisticism, horizontality and multilevel governance.

In order to work towards holistic, horizontal and multilevel addiction governance, a certain critical mass of political willpower is needed. Building such critical mass will in all probability be difficult and slow, however prior experience in public health advocacy, most notably in the tobacco field, shows that it is not impossible. In reality, a lack of political understanding of the available evidence, and a lack of vision of how it can be acted upon are responsible for the absence of a critical mass of political willpower to act on addiction.[1012] This thesis has shown that it is possible to embraces all three principle of good addiction governance, even within the constraints of limited resources,

[1012] See the remarks of UN Secretary-General Ban Ki-moon: 'Remarks to General Assembly Meeting on the Prevention and Control of Noncommunicable Disease' (2011) 1(1) The Global Journal of Health and Physical Education Pedagogy 72, 73.

through the careful design of an evidentially and theoretically supported strategic approach to tackling the factors of the addictiogenic environment. Therefore, a lack of momentum at the political level should really be seen as stemming from a lack of vision, rather than from the impossibility of action.

Given this, the absence of holistic, horizontal and multilevel addiction policy may be seen as a failure by governments to uphold right to health and stewardship duties. These duties require that governments do *all that they can within the limits of their resources* in order to tackle the addictiogenic environment. This is reinforced by the international commitment of states to step up actions in the fight against NCDs. The apparent lack of vision of Member State and EU policymakers in identifying the most important environmental factors that impact upon the development of addictions, and in attempting to identify which combination of legal interventions are most likely to be effective in changing these environmental conditions, does not meet the level of effort required by the ethical principles that legitimise the transfer of governmental authority in the public health and social fields in the first place.

In order to start building political awareness of how the addictiogenic environment works and what the most effective responses to it are, more detailed attention needs to be paid to the concept of the addictiogenic environment. Whatever name is given to the group of environmental factors that combine to increase the risk of individuals developing addictions, a deeper evidence base that is more explicitly concerned with the interaction between this group of factors and how they influence the development of addictions should be built. Further research should also be conducted to evaluate the potential impact of holistic, horizontal and multilevel design in addiction policy. The evidence currently available to policymakers is spread across multiple different fields of scientific and legal research, and often the links to addiction that exist between different research projects are not made, making it difficult for policymakers to connect the pieces of the puzzle. A unified evidence base is necessary, one from which policymakers can easily draw lessons on the nature of the addictiogenic environment and the combination of policy options that are most likely to constitute justified and effective control of that environment.

Efforts to do this are already being made – primarily in the form of the ALICE RAP project, which brought together a large of addiction scientists and policy experts over a five year period to build a more comprehensive evidence base on addiction. This project has built a highly comprehensive evidence base of the socio-economic and scientific determinants of addiction, the prevalence of

addiction and corporate influence in addiction policy, amongst other things, and should be welcomed.[1013] However, the ALICE RAP project was notably light on the legal aspects of addiction governance, and how policymakers can justify the adoption of renewed, stronger and more coherent forms of action that are supported by evidence. This is an area that must receive further research attention, if the specific evidence based starting to accumulate on the addictiogenic environment is to be accessible to policymakers, and can provide answers on how exactly they are to translate addiction science into addiction law and policy.

III. The EU has supranational addiction governance responsibilities

The second point that can be drawn from this thesis is that the EU has its own distinct responsibilities for addiction policy, in addition to those borne by its Member States. By conferring public health and social competences upon the EU, the Member States have entrusted the EU with the power to pursue at transnational level the principles embodied in the right to health, that is to say to the provision of conditions that will allow individuals to pursue their highest level of physical and mental health. By virtue of Article 168 TFEU, a high level of health is ensured in all EU policies and activities, and by virtue of Articles 9 TFEU and 151 TFEU the EU required to take into account the guarantee of adequate social protection, the fight against social exclusion and fundamental social rights. The EU is legally obliged under the Treaties to discharge a certain level of responsibility for health and social protection, which, considering the importance that has been attached at global level to the prevention of NCDs, must be taken to include all factors that contribute to the NCD burden, including the prevalence of addiction.

The EU also arguably holds stewardship responsibilities in the public health and social protection fields. In delegating sovereignty to the EU, the Member States have entrusted the EU with the authority and powers to ensure certain objectives of transnational cooperation that the Member States cannot achieve individually. Just as national governments owe stewardship duties to their populations, the EU – as a supranational organisation to which power has been delegated – owes stewardship duties to its Member States. The EU has so far failed to discharge its stewardship responsibilities in the field of addiction prevention. It does very little to tackle transnational elements of the addictiogenic environment, and sometimes even prevents Member States from discharging their own addiction governance responsibilities.

[1013] One can review the lines of research pursued by the ALICE RAP project, together with summaries of the deliverables produced by these lines of research, at: http://www.alicerap.eu/about-alice-rap/areas-a-workpackages.html (last accessed 3 August 2016).

These circumstances are, again, connected to the absence of political vision. In seeking to encourage EU policymakers to recognise their duties in relation to transnational public health and social problems, it will be necessary to address the perception of the EU's competence gap in public health and social matters. As the analysis of EU competence demonstrated, the gap between the EU's ambitions and its competences in NCD prevention can be bridged by the use of Article 114 TFEU. In situations where the EU could add value by creating harmonised standards of protection, this option has proved useful (as the analysis made clear, one must remember that this is not always where EU added value lies). However, if Articles 114 TFEU, 168 TFEU and 153 TFEU are to be used to their full potential, it will be necessary to address how the addiction competence gap is perceived.

The power to bridge the competence gap is available, and has indeed been used on isolated occasions in tobacco control. Greater advocacy is needed to encourage the Commission in particular to reconsider its currently stubborn refusal to apply EU competences to other addiction issues.[1014] This advocacy must focus on explaining how and why EU policymakers should use the full potential of the EU's public health and social competences in order to discharge the duties owed to Member States, and indeed EU citizens. In particular, advocacy should highlight the link between transnational factors of the addictiogenic environment and how the subsidiarity principle can 'cut both ways'[1015] in supporting the necessity of EU action in the field of addiction, rather than dismissing it.

IV. The EU can better use its competences to support the Member States

The third point that the analysis in this thesis has attempted to show is that it would be challenging yet legally possible for the EU to make more extensive and more effective use of its available competences to support the Member States in implementing holistic, horizontal and multilevel addiction prevention policies, and to create harmonised standards that will resolve conflicts

[1014] See the recent insistences of the Commission that EU legal powers will not be used to renew the EU's alcohol strategy, despite numerous calls from the Member States: H Jacobsen, 'Commission set to dump EU alcohol strategy' (22 May 2015, *EurActive.com*) available online at https://www.euractiv.com/section/health-consumers/news/commission-set-to-dump-eu-alcohol-strategy/ (last accessed 18 August 2015).
[1015] G. Lyon-Caen, "Subsidiarity", in P. Davies, A. Lyon-Caen, S. Sciarra and S. Simitis (eds), *European Community Labour Law: Principles and Perspectives* (Oxford: Clarendon Press 1996), 49.

between the obligations of the Member States to ensure the free movement of goods and their obligations to step up actions in the fight against NCDs.

As noted above, the EU's specific competences in public health and social protection are more powerful than EU policymakers want to acknowledge. However, even if national and European policymakers could be motivated to use these competences more often, the likelihood that they would be used to their greatest potential in contributing to holistic, horizontal and multilevel addiction governance is uncertain. Thus far, the only instance of Article 168 being relied upon in any addiction prevention context, the EU Alcohol Strategy, resulted in a highly ineffectual piece of policy, where Article 168 was relied on more as an excuse *not* to take strong action than as a tool of public health protection.[1016] The Commission clearly has the political mandate to go further in using competences such as Article 168 and 153 TFEU to support the addiction prevention activities of the Member States, but must take steps to reexamine the potential embodied in these complementary and coordinating competences if it is to most effectively act on this mandate.

Not only has the Commission not made full use of its supporting competences, it has also somewhat neglected the power of its competence to enact harmonised standards to improve the functioning of the internal market. This thesis has attempted to show that one of the ways in which the Member States would be best supported is through the removal of situations where their internal market obligations could conflict with their public health obligations and prevent the implementation of effective yet trade-restrictive addiction policies. It was shown that Article 114 TFEU is a powerful tool for ensuring that Member State's conflicting obligations on trade and public health do not prevent evidentially effective interventions from being employed in order to save lives. However, at present the EU has not used Article 114 TFEU to any great extent to support addiction prevention or NCD prevention efforts – aside from two directives in the tobacco control field, the potential of Article 114 TFEU as a tool of public health protection has gone unrealised.

In order to help European policymakers unlock the potential of the internal market, public health and social protection competences, greater advocacy by those with expertise in the use of EU competence in NCD prevention is needed in order to demonstrate how it is possible to maximise the powers conferred upon the EU by Articles 114 TFEU, 168 TFEU and 153 TFEU. Even if the critical mass of political willpower that is necessary for action on the addictiogenic environment is built, policymakers may not know the extent of the action that could be achieved. Thus, awareness of how

[1016] Bartlett and Garde, n 661 above.

EU competences could most effectively contribute to holistic, horizontal and multilevel addiction governance must be raised among EU policymakers and other concerned stakeholders, including awareness of how the use of these competences might be defended in the face of opposition.

V. A major obstacle to addiction policy is corporate power and influence

The final point that can be drawn from the analysis in this thesis is that corporate influence is a major obstacle to effective control of the addictiogenic environment of addictions. Corporations that produce objects of addiction not only try to increase the appeal of their products in order to drive up their consumption, they actively work against policymakers in a number of overt and covert ways in order to prevent the adoption of policies that would decrease consumption of their products or prevent them from promoting them.

Addiction industries will naturally lobby policymakers in attempts to influence policy when their commercial interests are threatened - this is simply a limb of their commercial strategy, a logical and legal extension of the fiduciary duties owed to shareholders that should be anticipated by policymakers.[1017] Unfortunately, the reality is that the intention behind much industry activity is not seen clearly by the policymakers. This means that addiction industries, in particular the alcohol, unhealthy food, and gambling industries, are still often treated as trusted partners, when the only quality of their engagement in policymaking that one can trust is that they will act in their own interests.

Since the number of corporate factors of the addictiogenic environment is high, there are therefore plenty of reasons for addiction industries to seek to preserve profits. The influence of corporations has on multiple occasions prevented the building of critical mass of political willpower to act on addiction issues, or has prevented or weakened the adoption of strong and innovative policies. This is unsurprising, given that companies that produce objects of addiction are one of the few industry groups that spend over a million Euros per year on EU level lobbying in order to influence the

[1017] S Chapman and S Carter, '"Avoid health warnings on all tobacco products for just as long as we can": a history of Australian tobacco industry efforts to avoid, delay and dilute health warnings on cigarettes' (2003) 12 Tobacco Control iii13.

direction of policy.[1018] Thus addiction problems push back ferociously against the efforts of policymakers to solve them, and require special attention if renewed efforts at effective addiction policy are to be effective.

Addressing the role of addiction industries in addiction policy is therefore a major challenge. In particular, addressing the perception of the industry's contribution to policymaking must be a high priority. In order to counter the power that the addiction industries have amassed, further work must be conducted to reveal the extent to which all addiction industries, not just the tobacco industry, operate to their own lobbying playbooks. This will help policymakers to identify when conflicts of interest might occur, and to deal with them appropriately.

The emphasis should be placed on dealing appropriately with situations in which conflicts of interest might occur, rather than ignoring altogether the contribution that might be extracted from industry actors in addiction governance. Corporations are complex entities, comprised of several elements, some of which have a genuine interest in health and well-being, some of which are interested in creating sustainable futures for their organisations while paying lip-service to health and well-being, and some which seek to deny entirely the impact of their organisations on health and wellbeing. This means that corporations may at times be able to offer useful perspective and advice to policymaking efforts, so long as conflicts of interests are avoided.[1019] In any event, since corporations produce the objects that addiction policy are concerned with, and possess fundamental rights to corporate speech and to conduct business, they cannot simply be shut out of the policymaking process. An interesting future for addiction governance might therefore involve research into how corporate forms might be altered to liberate the genuinely health-conscious elements of corporations from the fiduciary duties binding corporations to the pursuit of increased consumption and increased profit, and into how addiction industries might be incentivised to adopt such altered corporate forms.[1020] This may permit the limited yet productive engagement of corporate representatives in the

[1018] British American Tobacco (tobacco) and Diageo (alcohol) both spend in excess of 1.5m Euro per year on EU lobbying: http://lobbyfacts.eu/reports/lobby-costs/companies?page=1 (last accessed 18 August 2016). Furthermore, the 2014 Tobacco Products Directive was the most lobbied dossier in EU history: S Peeters et al, 'The revision of the 2014 European tobacco products directive: an analysis of the tobacco industry's attempts to "break the health silo" (2016) 25 Tobacco Control 108.

[1019] L Johnston and D Finegood, 'Cross-Sectors Partnerships and Public Health: Challenges and Opportunities for Addressing Obesity and Noncommunicable Diseases through Engagement with the Private Sector' (2015) 36 Annual Review of Public Health 255.

[1020] See for example research on Benefit Corporations in the United States, which are legally obliged to promote a chosen public good in addition to making profit: B Cummings, 'Benefit corporations: How to enforce a mandate to promote the public interest' (2012) 112(3) Columbia Law Review 578.

policymaking process, at a reduced risk of these representatives bringing conflicted interests to the policymaking table.

VI. Final remarks

This thesis has made the case that addiction policy is weaker throughout Europe due to the EU's lack of engagement, and that renewed and more intense action at EU level would better support the current activities of the Member States and discharge the duties that are incumbent upon the EU to address transnational threats to public health on behalf of the Member States. Some stakeholders have been fighting for increased action on addiction issues for some time, some are indifferent to such action, and some actively resist further action on addiction. If Member States are to control the factors of the addictiogenic environment more effectively, in order to step up action on addiction and NCD prevention, then building consensus between these disparate outlooks is essential. The EU could and should contribute to this process.

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